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JOURNAL
of the Medical Association of the State of Alabama
VOL. 51, NO. 1 JULY, 1981

RICHARD F. BLISS, M.D.

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The Colonel of Orangevale

See page 9

Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults.* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q i.d.; alcoholism, 10 mg t.i.d. or q i.d. in first 24 hours, then 5 mg t.i.d or q i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions) *Children:* 1 to 2½ mg t.i.d or q.i.d initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.

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On The Cover

For five years, Richard L. Bliss, M.D., was largely cut off from his busy general practice in Talladega. That was the period, which he refers to as his "sabbatical," when he was medical director of Alabama Medical Review, the state's PSRO. To keep his hand in, he bought this old log cabin for $100, moved it to the rear of Orangevale, his antebellum home, and saw patients there on weekends. Sometimes on a Saturday afternoon there would be 25 patients waiting in the yard. The unusual waiting room offers the sight of a Sicilian donkey, pheasants, ducks, geese, a Shetland pony and other residents of chez Bliss. Dr. Bliss still uses this office, fully air conditioned and nicely appointed, as an adjunct to his main office. Story, page 9.

The Man For The Job

The new Executive Secretary of the Board of Medical Examiners scarcely needs any introduction to the Association.

Larry D. Dixon was MASA Education Director from 1972 to 1976. In fact, Larry wrote the book on the department in its earliest days, since it fell his lot to initiate CME and get things started.

With his degrees in Political Science & Administration and History, and a career almost exclusively devoted to various aspects of medicine, you can believe Larry when he tells you that as Representative for the 81st District in the State House of Representative he has found the philosophy of medicine immensely helpful to him in his service on the Education, Health and Rules Committees.

After graduation from Washington State University, he did additional work at the Universities of Texas, Georgia and Alabama, chiefly in drug education. That was his field for two years with the State Department of Education, 1970-72. He was a consultant in educating faculty, students and community leaders about drugs and drug abuse.

He left MASA in 1976 to become Administrator of the Montgomery Family Practice Program, a residency program he was instrumental in setting up. From 1978 until his acceptance of the position with the Board of Medical Examiners, Larry has been director of the Jackson Hospital Foundation.

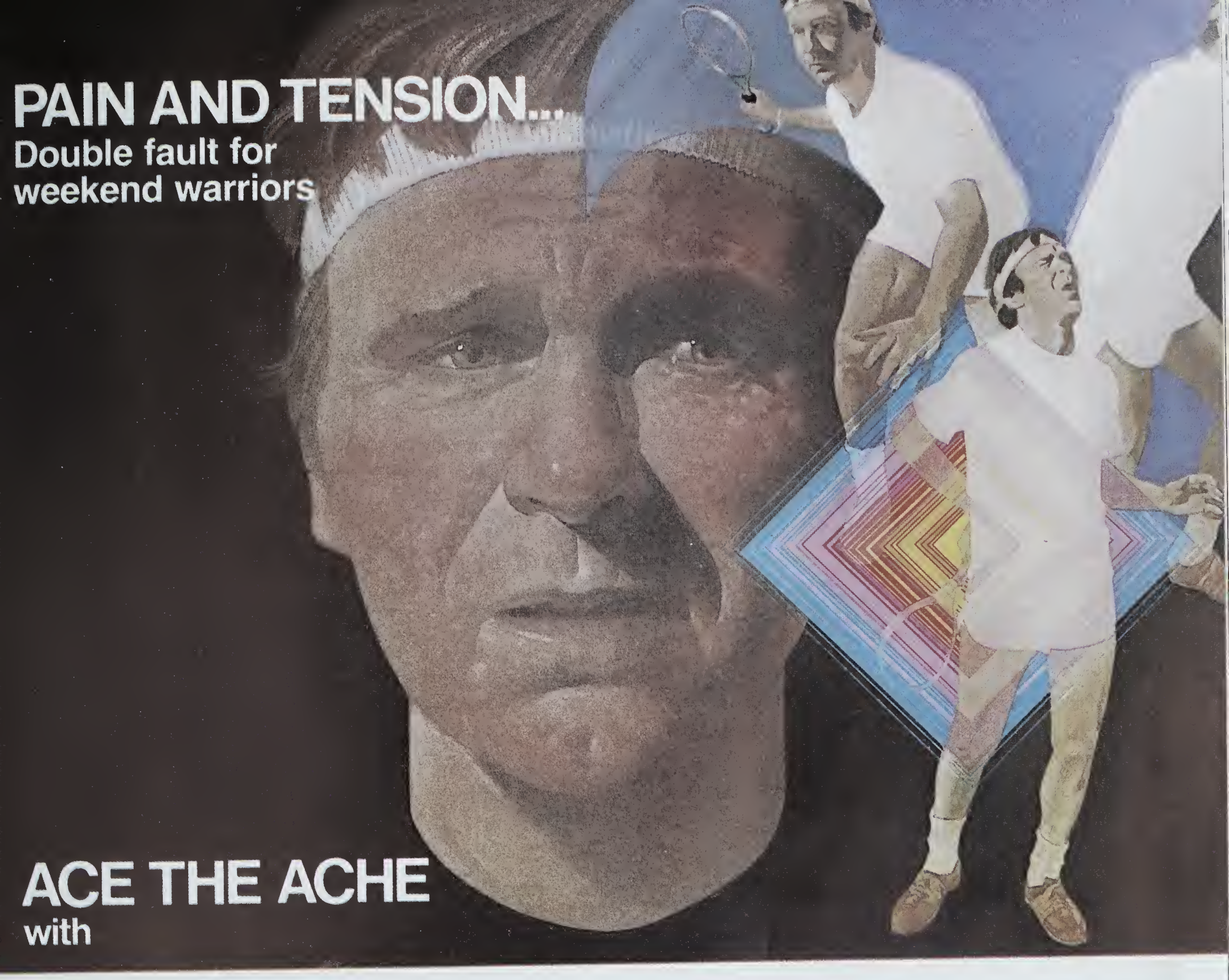
His record speaks for itself—he is a proven administrator with a special talent for organizing new enterprises in medicine. The Board of Medical Examiners is far from new, of course, but the creation of the Medical Licensure Commission made a whole new ball game of the Board's responsibilities, duties and powers. Still to be worked out are the details of the cooperative functions of the Board and the Commission.

While the act creating the Commission is detailed, obviously the mechanics of the relationship between the Commission and the Board have to be assembled more or less from scratch. There is no precedent in the state for the twin authorities: the old Healing Arts Board can hardly be compared to either, being largely a rubber-stamp agency with no real adjudicating efforts.

As the Commission and the Board work out their relationship, it will be the responsibility of staff to implement the policies and guidelines. And Larry, as chief administrator, will be calling on a lot of past experience in shaping and forming a good foundation for future growth. It goes without saying that in a relationship as important and sentitive as this, a good beginning is of vital concern to the profession and the public.

Larry is conscientious and capable; he has experience in spades. I know he will do a good job. I can think of no one better qualified for the unique demands of this very special relationship.

S. Lon Conner



Equagesic®(IV)

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

*__INDICATIONS:__ Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.
"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.
USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.
PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.
ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.
Impairment of accommodation and visual acuity has been reported rarely.
OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.
DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
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for mild to moderate pain

Wygesic®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e g driving a car or operating machinery Patients should be cautioned accordingly
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine
MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone, nalorphine and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I V , simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

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J. Kendall Black, Jr., M. D.
President

PRESIDENT'S PAGE

Health Planning Continues

At the recent business session of the American Medical Association, the House of Delegates reaffirmed its support of the concepts of cost containment, quality health care, repeal of health planning and elimination of federally mandated PSRO. Yet, at the same time, the House of Delegates reaffirmed the absolute need for medicine to reassert its leadership position in these areas. The Reagan Administration, the economy, the anti-regulatory mood of the country and the block grant concepts are all working in our favor with regard to these issues.

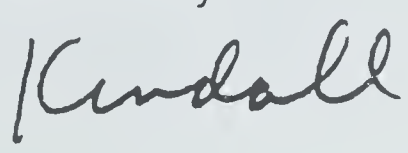
However, I think it important to recognize that bureaucracy as well as a nature abhors a vacuum. If, as it appears now, health planning and PSRO are repealed and/or phased out as federally mandated programs, it is our opportunity and even our responsibility to see that on the local and state level we participate in such programs. You and I each day carry out health planning on an individual basis for our patients. We carry out health planning when we set up our offices and maintain the supply lines to our offices. It is entirely logical that we expand our horizons to include our community and our state in assisting in health planning at these levels.

The federal government has no expertise with regard to health planning for the citizens of the State of Alabama. Medicine has expertise and should make it available to the citizens. Just as medicine itself would not attempt to design a computer without significant expert advise and counseling, we should not expect local health planners to design a health care system without intense, significant, and influential input from our profession. It is incumbent upon us to participate for there are indeed those who would impose upon us health systems designed to meet their needs and not the needs of the citizens of the State of Alabama.

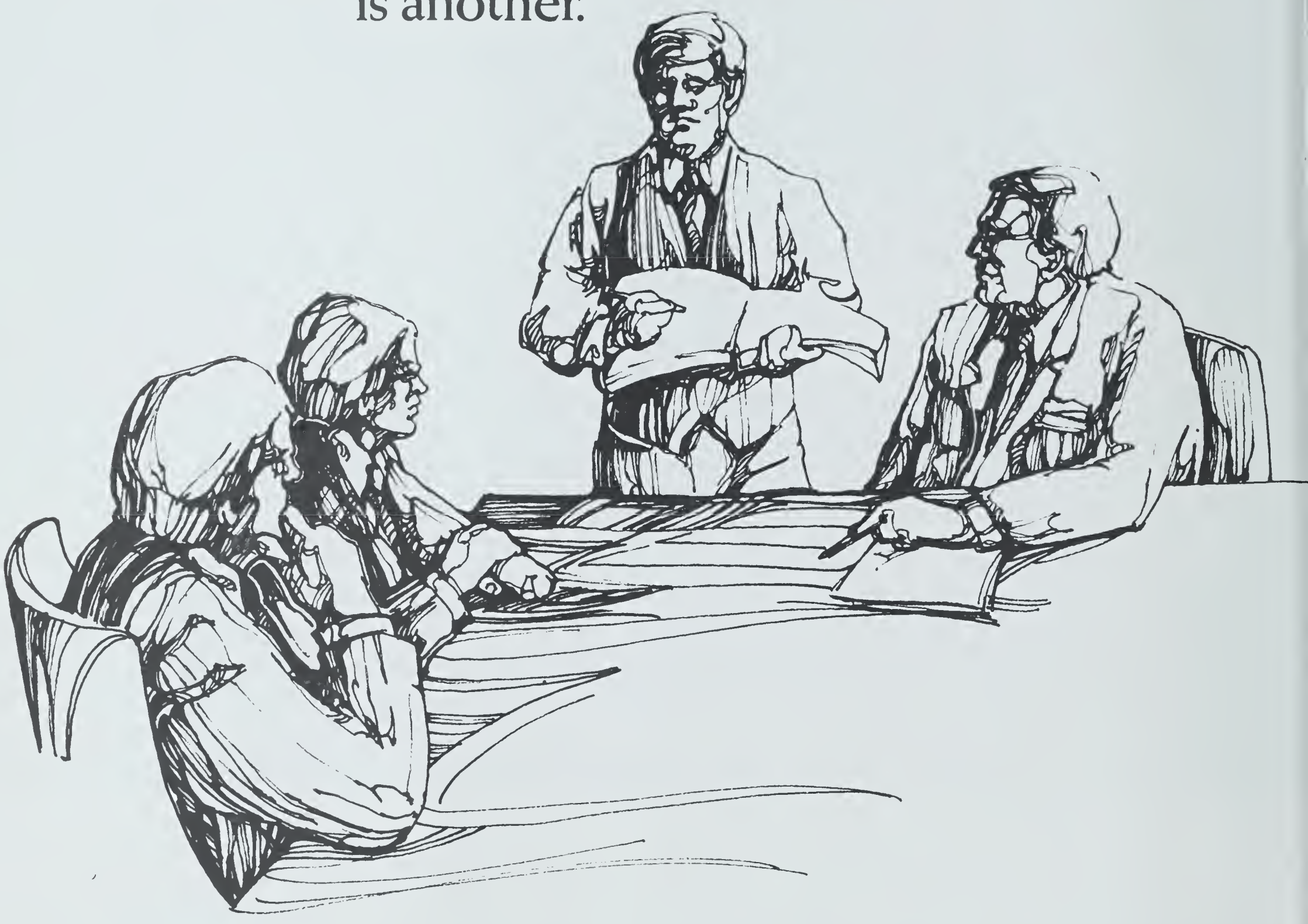
In terms of PSRO, the profession has been carrying our peer review for a number of years. It has been labeled utilization review, quality assurance, and has been disguised in many other ways. It is designed to see that the people of the State of Alabama receive quality health care from competent physicians in a cost-effective manner. However, it is not designed to see that cost containment is carried out at the expense of quality care as has seemingly been the case in many PSRO actions. We must continue to maintain the goals of quality care and we must continue the strive for cost effective quality care but not lower quality care in the name of cost effectiveness. Again I would say to you that it is not only our opportunity but our obligation to see that these goals are maintained and that we continue to strive for the attainment of absolute quality care for all citizens of the State of Alabama. I can guarantee you that if we do not do it then somebody will do it for us and to us.

At our recent cost containment conference participated in by industry leaders from across the state, it was obvious that they are more than willing, even eager, to work with medicine in the establishment of cost containment coalitions. I have asked each county society to establish a cost containment committee to meet with business and industry leaders in their area to evaluate, analyze, discuss and reach common solutions to common problems. We are already seeing thrusts toward the establishment of coalitions that exclude medicine. You and I are blamed for the expense and the burgeoning health care costs in this country. You and I have an absolute direct interest in seeing that cost-effective quality care is delivered. But we must be responsive to the needs of the consumer, industry and others in developing cost effective quality care. The federal government is having to get out of the regulatory industry. Let's not allow someone else to step in their place. The goals of industry and the goals of medicine can march in lock step together. Let's take advantage of that marching.

The next four years can be years of golden opportunity but these are opportunities which must be seized and grasped firmly or they will pass us by. I am confident of our ability to reach common solutions and to assert our leadership in health care delivery.



Patient care is one difficult issue that doctors tackle. Peer review is another.



Blue Cross and Blue Shield salutes the Medical Association of the State of Alabama for its decision to reinstitute peer review. Self-monitoring by members of the medical profession is one of the most effective ways to keep the costs of health care—and the costs of health insurance—under control.

Peer review allows for the examination of fees or services that may be in excess of what is considered usual, reasonable and customary. The final decision as to what constitutes usual, reasonable and customary fees or services is made by the Medical Association's Board of Censors. Extenuating circumstances, such as unexpectedly lengthy surgery, or complications leading to additional procedures, are taken into account. The decision of the board is binding. And in cases where disputed costs are found to be usual, reasonable and customary, Blue Cross and Blue Shield will abide by the board's decision and pay the settled amount.

Blue Cross and Blue Shield finds peer review a positive action in the ongoing struggle against escalating medical costs. It is important to realize that most physicians do not overcharge for their services. When peer review is fully reinstituted, physicians and the people who pay for it will have a forum for the judgment of reasonable costs.

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PROFILE

The Colonel of Orangevale

By William H. McDonald

It was late Saturday afternoon on a hot June day at Orangevale, Talladega, Alabama, after another week of the kind the Colonel likes—long hours of practicing medicine among the people he has known and loved for 30 years; long hours at daybreak and dusk tending the polled Herefords, the sheep, goats, pheasant, and the other ancillary personnel of a proper farm.

The Colonel had earned the brief privilege of sitting in the shade of one of his giant trees, swinging slowly back and forth in one of those slat-bottom rigs that graced every porch in the South before porches were replaced by the tube.

A freshly compounded mint julep in hand, the Colonel was holding forth on his two favorite subjects: medicine and farming. But even as he talked he kept a weather eye cocked to the West: over by Sleeping Giant mountain, surly clouds were milling around trying to form a mob.

At the foot of Sleeping Giant, Buford, the Colonel's prize King Domino bull, possessor of the family jewels that might one day restore Orangevale to its place in the sun, was languidly chewing, storing up potency for his role as the live-in lover of fine Hereford cows.

"I think we're going to get some more rain," the Colonel said, resting the heavy silver mug on his knee, "and we don't need that right now. Last weekend, we had just mowed the hay when it started pouring. Ruined my hay. That's the way it goes."

Two weeks before that, another thunderstorm spawned a twister down there in the pasture, about where the meadow meets the foot of the mountain. It roared up over Orangevale, selecting the Colonel's prize hickory tree—heaven knows how old—slamming it on the roof of his 1852 plantation house, smashing the roof and funneling gallons of water through the house.

Still, you expect things like that, the Colonel mused, smiling with satisfaction. You accept the risks that go with the territory. He hadn't expected a rose garden when he started practicing medicine in Talladega country 30 years ago and he hadn't expected (or wanted) a life of moonlight & magnolias when he bought the faded elegance of Orangevale a dozen years ago.

He's Authentic

There is nothing phony about this Colonel. He is for real. He holds a reserve commission of bird colonel in the United States Army and heads up a tri-state medical readiness group that would be called up whenever the balloon goes up.

News from the Middle East may seem remote to most Alabamians. But not to the Colonel. The Israeli air strike against Baghdad, for example, could have meant war that might involve American forces. The Colonel has to think of things like that even as he worries about his patients, the rain, the bull and the danged woodpeckers that have been perforating one of the majestic columns of his manor house.

If war comes, committing U. S. ground forces, "I would be out of here before dawn" the Colonel says. "Somebody has to provide medical care for our troops. I'm it."

Specifically being It means he is Staff Surgeon of the 121st Army Reserve Command, headquartered in Birmingham. He commands all medical reserve units in Alabama, Mississippi and Tennessee.

The Colonel takes a discreet sip from his julep cup, checks the gathering storm again, sniffs the rising wind for the smell of rain, indulges himself in a couple of arcs in the swing, sets his jaw and says:

"I joined the Marines in 1943 and lost two or three years in school. I stayed in the Marine reserve as an artillery officer during medical school. Then I was attached to the Navy reserve for awhile but I stayed in when I was about the only doctor in the military, when people thought bad of the military. People right here in Talladega would say, 'What are you doing that for—are you crazy?'

"No, I'm not crazy. This is my country and if we go to war who will look after the casualties? We do not have enough active medical personnel to take care of casualties anywhere in the world if we had a Pearl Harbor. What would the country do? In 30 days, we might be able to get more people, but what about today, tomorrow, tonight? This is my job, my reserve response. As coordinator of medical reserve units in three states, I would be out of here before dawn, to whatever hemisphere I am needed."

The Colonel says all this in a flat, matter-of-fact monotone. It is a statement totally without bravado.

Pursuit of Simplicity

You look at Dr. Dick Bliss, the Colonel, and wonder: Isn't he just a little too good to be true? His patriotism is of the kind that it is fashionable to laugh at in some circles these days. But for 38 years he has faithfully maintained his military connection, firm in his belief that

whatever is wrong with the country, and a lot is, it is still the greatest nation on earth.

The pursuit of simplicity perhaps describes the life of Dr. Bliss. He cares little for the fussy trappings of pretense, despises sham and deceit. Much of the gadgetry of modern life turns him off. He teaches Sunday school, the Old Testament. He has served 10 years as chairman of the school board and in other tiring, unspectacular community work. He has slogged over mountains in the dead of winter to deliver babies before dawn, performed emergency trauma surgery at all hours, sewed up farmers, ministered to the sick and buried the dead. He has won more than his share of the endless battles against disease and death, but he has taken his losses too.

He has always given his best. Traveling the backroads and cowpaths of the hills and hollows of Talladega County, he has brought modern medicine to people who need it. He has been part of their lives and they of his. He has never felt put upon by the long weeks of endless nights and days. He doesn't feel put upon now, although he has tapered off to 50 or 60 hours of week. He wouldn't feel persecuted if the Army called him tomorrow, or tonight, and sent him God knows where.

He didn't feel persecuted when the twister threw his hickory tree into his house. In fact, he never really decided which was worse, the loss of the tree or the damage to the house he and his family have been lovingly restoring for a dozen back-breaking years. "Sweat equity" has a special meaning in the Bliss family.

Dr. Dick Bliss has a homey (some would say outmoded) since of Duty, capitalized. Duty to his God, Duty to his Country, Duty to his fellow Man. All capitalized. He has never wavered in that. If people laugh at him for his old-fashioned dedication, scorn him for his patriotism—and people have—he just smiles, much as the Old Testament prophets of old (a special area of current study for him) must have smiled. And he goes about his business, doing this Duty by his lights, guided by an inner conviction of justice and rectitude—suffering fools gladly, more or less.

An Off-The-Bench Opinion

Justice Richard L. (Red) Jones of the Supreme Court of Alabama knows Dr. Bliss well and admits to being somewhat unjudicial in the following evaluation of the man, since "we have solved all the world's problems too often for me to say anything bad about him."

The Justice's curbstone opinion of Dr. Bliss:

"When we pick up the record of a trial, we can tell whether or not the trial judge has what we call 'a sense of the law.' That means that the judge who has it not only knows the law, but knows what it means and how to apply and adapt it.

"While I am not in Dick Bliss's discipline, I would say he has 'a sense of medicine.' By this I mean he is able to go beyond medicine to use that common sense he has and that deep sense of humanity that he has to give the practice of medicine an extra dimension. I know of nobody else in medicine who has this human touch in the way I mean it. I'll give you an example:

"I sent an old black man to Dr. Bliss once, a man I thought was malingering. I think I was really trying to find a reason to get rid of him and I was using Dick Bliss as the means of it, I think—not consciously, maybe, but unconsciously. He had been complaining of severe headaches, disabling headaches, long after he had gotten a bad blow on the head. I thought he should be all right. Dick called me back and said: 'I don't have all the answers yet, but I wouldn't be too quick about judging this fellow because he's got one thing going for him, one thing that makes me doubt he is malingering.'

" 'What's that?' I asked, and Dick replied:

" 'Well, he has worked hard all his life and had a perfect work record. Never complained. His greatest forte in life has been his ability to work and bring home that paycheck. Now for some reason, he's not doing it. So there's got to be something wrong.'

"Dick kept on until he found it, something the city doctors were missing. A cranial nerve had been injured by that blow. Dick sent him back to the neurosurgeon and told him to check what he had found. The neurosurgeon did and he found it. He went in beneath the surface, left side of the head above the eye, and severed the nerve. Why, that man was back to work in a week.

"That's what I call having 'a sense of medicine,' and I'm not really sure what it is."

Justice Jones seems to think Dr. Bliss also has a fair sense of justice, as in the following story:

"An old black man got drunk and killed another one. Everybody had just given up on him and decided he would have to go to jail. But Dr. Bliss decided, No, he shouldn't because the better one killed the sorry one. The way he finessed that and got the old fellow off, giving him a few more years of freedom until he died, was very impressive.

"I guess the funniest letter I ever got was one from Dick in which he described the case of a boy who had lost his manhood in a terrible industrial accident. The proudest moment in that boy's life, Dick wrote, was when he presented with a case of VD. 'I have been a witness,' Dick wrote, 'to one of man's greatest hours.' "

In summary, the Justice says of Dr. Bliss:

"There is a basic conservatism about him that can fool you. There are so many apparent paradoxes in his views about different things, sometimes you think he's not being consistent—until you know him better. Then you realize he's **always** consistent, right down the line, in every opinion he has. He is a super human being."

He makes short shrift of those he perceives as railbirds. For example, he moves easily in academic circles, having taught for a time in the Family Practice program, but refers without rancor to the Medical Center in Birmingham, just beyond Sleeping Giant, as the "concrete jungle in which the most vicious animals known to man roam unchecked." He tells his doctor friends there they are crazy to stay in the jungle. Just as likely, they think he's crazy for preferring life out there in the boonies.

But, after 30 years of rugged practice, doing it all, things are coming together for Dr. Bliss.

It began, inauspiciously enough, with his wife's decision to have a look at a run-down old house she had heard about back in 1969. At the time, the Blisses had been planning to build a house "as modern as tomorrow" on the lake. The words are those of Mrs. Bliss, an artist and recently turned interior decorator.

They had been living in town since Dr. Bliss opened his practice in 1951 and wanted a home of their own design. That was the plan. The switch came when Mrs. Bliss and her two daughters visited the elegant ruins of Orangevale. They fell in love with it, to Dr. Bliss's initial consternation. He had passed the old place dozens of times making house calls but mentally wrote it off as another example of decay of a life that once was but is no more.

"It certainly isn't as modern as tomorrow," he demurred.

Three women, however, can be powerfully persuasive. In no time, to Dr. Bliss's considerable surprise, they had bought the house and the 107 acres remaining in the 2,300 of the original plantation, and set about restoring it, a job they knew would never end.

Call of the Soil

The farm was a dividend that, at first, Dr. Bliss regarded only as a hobby. But somewhere in the bones of all people a generation or two removed from the soil is the dormant love of land and growing things, perhaps accounting for the proliferation of gardens in Southern cities. Once reactivated in Dr. Bliss, such genetic coding as may have been there all along took over and he now says quite simply:

"This is my investment, my retirement program, physical fitness program and hobby, all wrapped into one."

The Colonel and His Lady—also known as Dr. and Mrs. Dick Bliss of Orangevale.

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Social scientists have noted a modern variant to the old saying, shirtleaves-to-shirtsleeves in three generations. The variant goes: farm hand to farm hand in three generations. The country boys migrate to the city and raise families in the land of opportunity, or what is perceived to be the land of opportunity. The next generation or two improves its urban lot. Then along comes a generation that begins to question the city as the be all and end all of human existence and happiness. Out they go, back to the country their great grandfathers had left.

During the 70s, the historic tides of this century, rural to urban and South to North, began to reverse. The results are seen in the 1980 census: people moving out of the cities to the long abandoned rural areas and retreating from the great cities of the North back to the South.

Dr. Bliss didn't have to migrate. He simply lowered his buckets where he was and found the good life of Orangevale.

What happened along the way at Orangevale was that one of Dr. Bliss's sons, Bill, took a professional interest in the potentials of cattle farming. He enrolled in Mississippi State's highly regarded joint program leading to combined degrees in Agriculture and Business Administration.

Bill, 21, will graduate next summer. His objective is both practical and visionary: he wants someday to reacquire all of the plantation's original 2,300 acres and to put Orangevale on the map as a leading breeder of Polled Herefords, specifically the King Domino bloodline. The nucleus of his herd is already in being, Buford the blase´ bull.

While Dr. Bliss looks on beaming, ill concealing his satisfaction with Bill's decision to make Orangevale a major cattle producer, Bill says:

"Kimberly Clark has the lease now, but eventually I'd like to get back all of the original plantation. This part (that presently owned by Dr. Bliss) would be my bull farm. I would wean my bulls and grow them here. My brood stock would be down the road. I'm picking up a lease now about five miles down there but eventually I would like to see the whole 2,300 acres, like Dr. Hicks did in the Angus world at Union Springs."

Chips off the Block

Bill is the fourth child. The oldest daughter is a medical school librarian in Birmingham, the second daughter is married to a Mobile attorney. The other son is working in Auburn. While all the children love to return to the farm, as for a recent barbecue Dr. Bliss gave, Bill is the farmer created by the Orangevale life.

While Dr. Bliss has achieved a fine symbiosis with small town/country life, he is not native to the heath. He was born and raised in Birmingham's Woodlawn area. He was a pre-med student at the University of Alabama when he decided to join the Marines in 1943. Commissioned a second lieutenant, he saw service on the *U.S.S. Alabama* and had almost decided, at war's end, to make the Marines a career.

He had already put in for a regular commission when he stopped by Tuscaloosa while on leave to casually inquire about his chances of getting into medical school that year, 1946. Not much chance, they said, but promised to check.

Back at his station at Norfolk, Virginia, he received, in a single week, (1) notification of his acceptance for a regular commission in the Marines and (2) his acceptance at the University, provided he went to summer school. His indecision was short-lived; he opted for medicine, although he has remained in the reserve—Marines, Navy or Army—ever since. In a couple of years, he will begin drawing retirement pay after 41 years of unbroken military service, beginning at age 19.

Staying on Course

Dr. Bliss takes his military obligations, like everything else, very seriously. He has never faltered in his belief that the country is worth any man's dying for. His old-fashioned patriotism is so secure it never failed him during and after the long Vietnam period, when the military become an odious occupation, even in Talladega.

Dr. Bliss only smiled when people ridiculed him for his continued faith in his military work, just as he has always grinned and shook it off when his city doctor friends asked him why he didn't leave the boonies. His taste of academe, and an offer of a full-time place in the sacred groves, were not seductive.

After five years of service as medical director of Alabama Medical Review, he couldn't wait to get back into private practice in Talladega. During that hiatus, he took on the assistant professorship in family practice at the University.

"Y'all keep telling me I'm a family practitioner," Dr. Bliss would twit his teaching colleagues, "but I maintain I'm an old-fashioned GP and getting prouder of it every year."

A Contented Man

And now? Glancing disapprovingly at the gathering thunderheads, Dr. Bliss then stares meditatively at his mint julep and says:

"I am happy to sit here and be the Colonel of Orangevale and have a mint julep with my friends. I don't ever expect to retire. My idea of retirement is what I am doing right now: that's about 50 hours a week of medicine and the rest of the time working here on the farm."

Dr. Bliss believes that physicians, more than other professionals, must become a part of their community. He deplores the apparent decline in the belief that the doctor should be a community leader, that he has duties beyond curing diseases and relieving pain. Having served his 10 years as chairman of the Talladega School Board and other examples of civic rent paying, he is biting in his criticism of younger physicians who, he says, seem little concerned with their obligations either to their community or to their country. Matter of factly, Dr. Bliss observes:

"If we had a Pearl Harbor right now, I would be gone before dawn tomorrow. I expect to go. I want to go. But this is a philosophy that is absolutely foreign to younger physicians. They don't know what I'm talking about."

He seems to be saying that a medicine's much discussed specialization has had some slop-over effects into the life of the community and the nation. As many doctors have lost the long-term involvement in the lives of patients, so have they lost involvement in community affairs. Dr. Bliss thinks this isolation, as he sees it, is doubly dangerous—it tends to dehumanize the physician and it also denies his community the benefit of his cultural and intellectual contributions.

There may be some of Dr. Bliss's Old Testament prophetic view in the stinging comments he has on a variety of medical subjects. A few excerpts follow:

"My generation is gone, my kind of medicine is gone. And there is no one replacing us. The family practitioners are not. Sometimes it seems the best they could do in a setting like this as the primary care doctor is to make referrals, to triage.

"Family practice residency, I'm afraid, is a general internal medicine residency with a little pediatrics thrown in. You're not qualified to do cardiology; you're not qualified to do operative obstetrics; and you're not qualified to do anything involving surgery.

"On the other hand, my generation, the old GP, did it all. I don't believe they are replacing us. Nobody is. If I had to advise a young man today I would tell him to take his residency in general surgery, if he wanted a job like this. Then he could do most of the things I have done all along—operate, treat medical illnesses. Then if he wanted to go to Podunk, he would be a GP."

It's Dr. Bliss's thesis that Podunk still needs the GP type and that the coming oversupply of physicians could be best utilized if this generation of doctors were trained to fill the GP's shoes in Podunk. Dr. Bliss thinks they are not so prepared.

Another major hazard Dr. Bliss sees in the changing practice of medicine is the increasing power of hospitals, and the hospital establishment, specifically including the Joint Commission and nurses.

He says:

"In my swan song speech as medical director of Alabama Medical Review, I emphasized that the key word in Professionals Standards Review Organization was *professional.* Now, PSRO is going by the board but review is not. Review is going to be under the auspices of the intermediary and the Joint Commission.

"When I was leaving, I tried to tell them in Birmingham that bureaucracy is not something that is confined to Washington, that the worst bureaucracy is the Joint

Dr. Bliss's son Bill is determined to restore Orangevale to its original 2,300 acres. The sheep is a registered Suffolk. The Blisses, father and son, believe sheep-raising may have a new future in the South.

Commission. In all my years with AMR, I have been to every hospital and every county medical group in Alabama. I have probably talked to more medical groups than any doctor in Alabama. I got blamed as PSRO medical director for all the things that were Joint Commission regulated.

"PSRO will go but the profession will find that all those regs are still there, and they come from an agency they say is 'ours.' The Joint Commission is just as big a bear as the federal government."

In his Orangevale life, Dr. Bliss is trying to restore not only the physical grandeur of the old South but its manners as well. Those qualities of gentility, duty, honor, personal integrity he brought to Orangevale blend easily with his vision of the style of life that the Bliss family should establish at Orangevale.

That is evident even in his careful preparation of the mint julep; in the deliberate swinging out back by the barbecue pit; in the philosophical acceptance of the hickory tree's fall; and in his high dudgeon over the depredations of the Yellow Bellied Sapsucker. The villainous assaults on his columns is not an Act of God, Dr. Bliss believes, not some natural disaster you should accept with stoic grace. It's a dastardly act of war by a yankee invader. The whiff of grapeshot is heard often around Orangevale these days as the Colonel warms to his task of seeking and destroying this enemy of His Way of Life.

The Past Lives

The rains have started up there in the Sleeping Giant and the Colonel signals that its time for his guests to repair to the big house for supper. The wind slams through open windows and doors and your almost expect to see the original owner, Brig. Gen. Levi Lawler, a planter as well as a Mobile merchant and state legislator during the Civil War days.

If you are the type to fancy spirits still around, you might imagine the Gen. Lawler expressing concern for his more than 100 slaves on such a night as this.

But as you sit there in the room General Lawler must have used when he wrote of the despair of the Reconstruction period, it is easier to understand the indomitable spirit of the Dr. Dick Blisses and others who came after.

Lawler wrote from Orangevale in 1876:

"My losses in various ways have reduced my means greatly. I am becoming poorer every year. It seems I shall never get through with old troubles. I shall hardly realize anything in my lifetime. I am left without enough to support my family. For 40 years I have been a hard worker and now at the age of 60 I would like to retire from active commercial pursuits. I am tired. . . ."

This tragic story of the Old South in ashes and economic ruin was repeated thousands of times during that bitter period of American history. But, Phoenix-like, Orangevale stands today, more than a century after Lawler wrote these words, once again proud, and once again the property of man whose belief in the old virtues of duty and honor would have won the General's approval.

Dr. Dick Bliss is, indeed, the Colonel of Orangevale.

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Gastrointestinal: Nausea;* epigastric pain;* heartburn;* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness;* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

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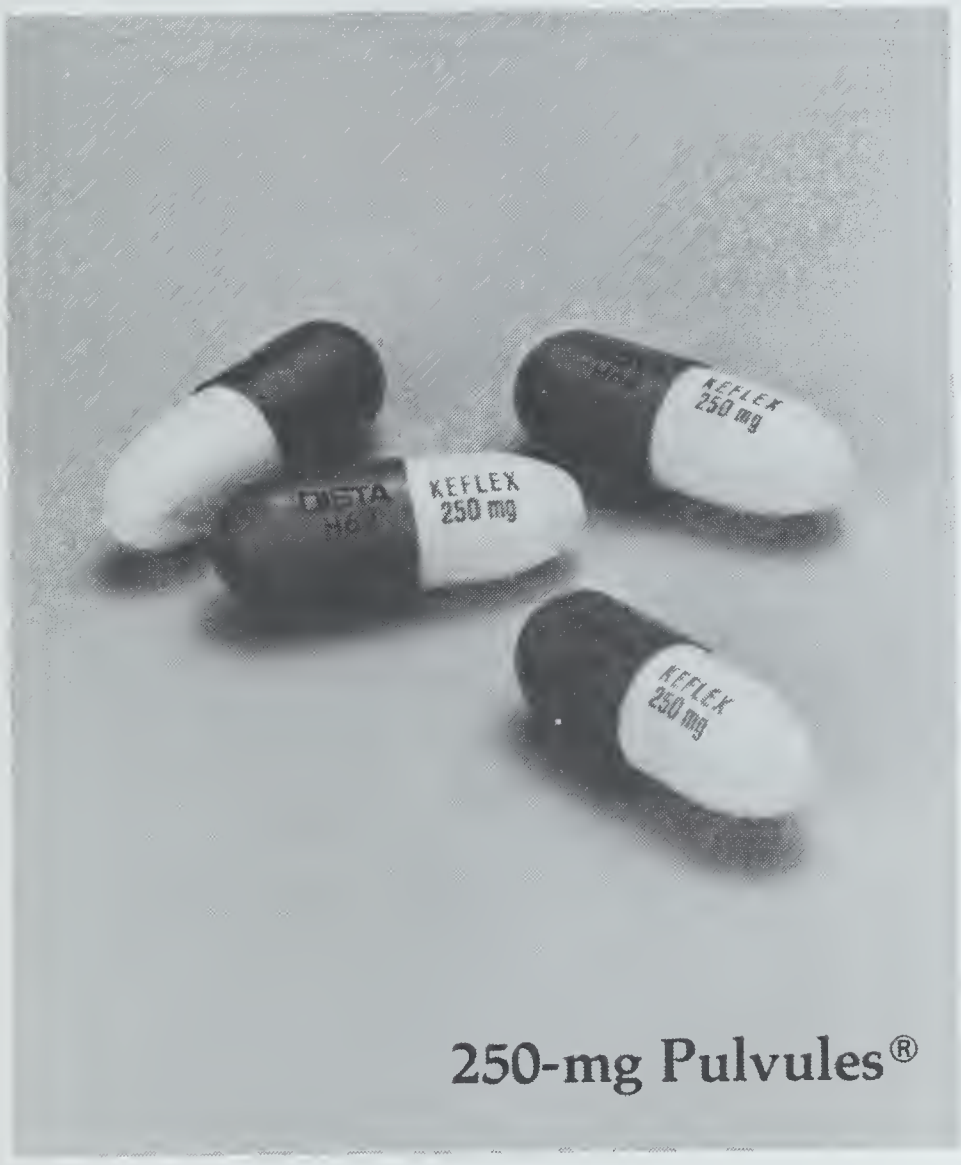

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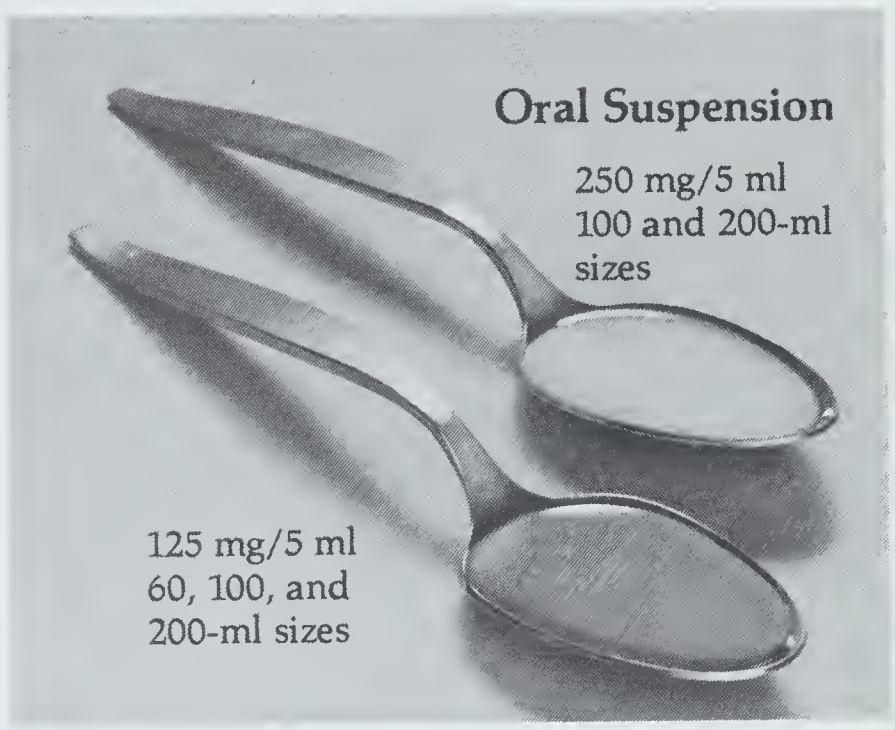

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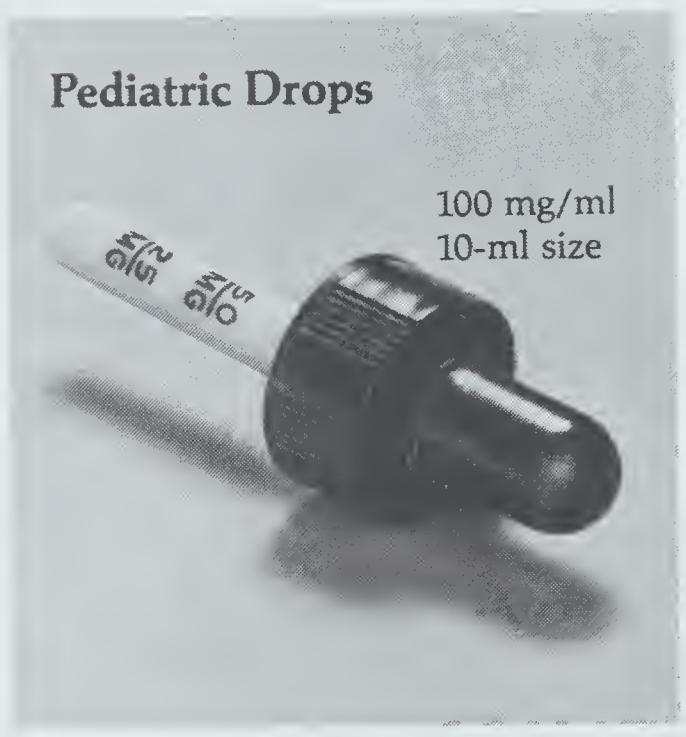

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The first issue of the Journal appeared 50 years ago this month, on July 15, 1931. To commemorate 50 years of Alabama medicine, various authors over the state are writing articles in their fields of specialization and interest. These will appear over the next several months, identified by the 50th Anniversary logo.

The first of the half-century articles, "Fifty Years of Cardiology in Alabama," by H. Duke Thomas, M.D., follows. Dr. Thomas is a member of the nine-physician group, Cardiovascular Associates, of Birmingham.

Fifty Years of Cardiology in Alabama

By H. Duke Thomas, M.D.

The first major influences on the "heart consciousness" of physicians in Alabama probably came through the pupils of Samuel Levine and Paul Dudley White, who practiced and taught at the Peter Bent Brigham and Massachusetts General Hospital in Boston. One of the first pupils of Paul Dudley White to practice and teach in Alabama was Dr. John B. Burrett, who located in Birmingham, immediately after the end of World War II.

Dr. Burrett was in charge of the electrocardiography laboratory at the Jefferson-Hillman Hospital and Clinic, which was the teaching hospital of the newly created four-year medical college of Alabama. He taught classes in electrocardiography to students and housestaff and was an attending physician on the wards in the early years of the medical school. He immediately established a successful practice in Birmingham, and served as a consultant to many physicians in the city as well as in surrounding towns within approximately a hundred-mile radius.

One can appreciate the newness of the concepts in heart disease when consideration is given to the time lag between the publications and widespread recognition by practicing physicians of new information pertaining to the diagnosis and treatment of heart disease. Dr. Tinsley Harrison has stated that most medical students and house officers of the 1920 to 1925 era never heard of the disease entity of myocardial infarction during their period of clinical training.

The system of precordial electrocardiographic leads, which greatly enhanced the chances of obtaining specific objective evidence of acute myocardial infarctions, was not introduced by Frank N. Wilson until 1944. The electrocardiogram and chest x-ray were the only tools available to the early physicians to supplement the history and physical examination in the diagnosis of heart disease.

Dr. Tinsley R. Harrison came to Birmingham, Alabama in 1950, as acting Dean of the Medical College and Chairman of the Department of Medicine. He had received his clinical training in medicine at Johns Hopkins University and the Peter Bent Brigham Hospital. He had become an outstanding Professor of Medicine at Vanderbilt University where he taught and carried on research.

His book **Failure, the Circulation,** was published in 1936, when he was associate Professor of Medicine at the Vanderbilt School of Medicine. While at Vanderbilt, he was associated with and was influenced by Dr. Alfred Blaylock, who later went to Johns Hopkins School of Medicine as Professor of Surgery. Dr. Harrison was in the process of publishing his text book, **Principles of Internal Medicine** when he came to Birmingham.

Soon after his arrival in Birmingham, Dr. Harrison was able to attract Dr. Richard Bing, who was carrying out the newly developed technic of cardiac catheterization at Johns Hopkins University School of Medicine. This technic was a valuable aid in the diagnosis and evaluation of patients who were candidates for cardiac surgery. Surgery was becoming an important method of treatment of selected patients with congenital and rheumatic valvular disease. The Medical College of Alabama was fortunate in having Dr. Champ Lyons, Chairman of the Department of Surgery, and Dr. Sterling Edwards, Professor of Surgery, and Dr. Charles Donald, Clinical Professor of Surgery, who pioneered heart surgery in the state.

An indication of the University of Alabama Medical Center's ability to attract talent was the appointment of John W. Kirkland as Chairman of the Department of Surgery following the death of Dr. Champ Lyons in the mid 60s. Dr. Kirkland had already become world renowned as a carciac surgeon, using the open heart technic. Dr. T. Joseph Reeves had succeeded Dr. W. P. Frommeyer as Chairman of the Department of Medicine.

The list of full time faculty and fellows in the cardiovascular division had grown steadily since the beginning of Dr. Harrison's tenure. The list included Dr. Loyd Hefner, who was first to occupy the Alabama Heart supported Chair of Cardiac Research. Dr. Thomas N. James also joined the medical school as Professor in Medicine, and later succeeded Dr. T. J. Reeves as Chairman of the Department of Medicine. They, along with Lionell M. Bargeron, Jr., Pediatric Cardiologist, cooperated with the cardiac surgeons in establishing a well-balanced heart training and research program. The program included coronary angiography and coronary vein bypass graft surgery in the management of cornary artery disease.

A corollary growth occured in the private practice sector in Birmingham. It was Dr. Burrett's philosophy to add newly trained physicians to his group practice periodically. He was instrumental in persuading the new Baptist Medical Center-Montclair Hospital to include a heart catheterization laboratory. This laboratory was soon to embark on the procedure of coronary arteriograms. In the meantime, two new surgeons who had finished training under Dr. Kirkland joined Dr. Charles Donald's group. They enjoyed success in carrying out coronary artery surgery, comparable to that at the University Medical Center.

Dr. Burrett, forseeing the need for expansion of the coronary surgery program, was instrumental in the inclusion of coronary angiography laboratory at the new Brookwood Hospital. To meet the needs of this surgical therapy of coronary artery disease, the group of Dr. Charles Donald's increased to a total of seven, while Dr. Burrett's group of cardiologists increased to ten. Many of these well trained physicians came from the University Medical Center, but a sizeable number came from other medical centers throughout the country.

There have also evolved similar programs by cardiologists and cardiac surgeons in many other community hospitals in the city of Birmingham as well as in other cities in the state. The directory of the State Medical Society for 1980 lists 17 cardiac thoracic surgeons and 26 cardiologists who are in practice in the state in cities other than Birmingham.

The magnitude of the program of coronary artery surgery can be appreciated when it is considered that there are now approximately 100,000 coronary artery surgery procedures performed annually in the United States.

The cardiologists and cardiovascular surgeons have organized a Birmingham Cardiovascular Society, which meets periodically to discuss common interests and advances in clinical research. There is an exchange of information regarding additional diagnostic methodology at both University Hospital and the Community Hospitals. Notable accomplishments have been the development of coronary care units for taking care of patients with acute coronary heart disease. The close monitoring of the cardiac rhythm disturbances has contributed significantly to the management of patients with these life threatening complications.

Another important development has been the clinical application of pacemaker implantations in the patients with chronic or recurrent disturbances in cardiac rhythm. The monitoring of electrocardiogram recording during a 24-hour period in the ambulatory patient has been of great significance in the understanding and treatment of patients with recurrent cardiac dysrhythmias.

Another diagnostic procedure which is receiving increasing clinical application is echocardiography, both M-mode and two dimensional. Radionucleide imaging is another method of evaluation of heart which is under study by many cardiologists. The place of percutanous angioplasty in the treatment of patients with coronary artery obstructive desease is under investigation by some of the cardiologists in the state.

The calcium antagonists drugs, which are in use in Europe and under clinical investigation in the United States are of interest to the cardiologists for the drug therapy of angina pectoris and cardiac arrhythmias. Attention to the risk factors in coronary artery disease, particularly hypertension, cigarette smoking and cholesterol may have contributed to the decline in death rate from heart disease. However, discover of the cause and prevention of atherosclerosis remains the greatest challenge confronting the cardiologist today.

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FATHERS MUST BE MEN

By
Claude L. Brown, M.D.*

It seems to me that much is written for the edification and occasionally the bewilderment of mothers, but that dear old Dad is not given so searching a look.

Is this lack of attention to father because our society places more emphasis on mothering than it does on fathering? Is father really so insignificant? Can his role in family life be likened to his role in fertilization, i.e., simply supplying a small but necessary ingredient, after which the egg continues to grow and transform itself in mother without any further help from the tiny sperm cell? His impregnating accomplished, is father then relegated to a passive, spectator role, not only during the gestation of his child, but after its delivery? This new life, created in part by father — Can it truly mature without much further constructive influence from father?

One of my patients said aptly, "I don't know how to be a man because my father was never interested in me."

The same is true of a girl; she can't be a man-needing woman unless she early felt warmth, affection and interest from a man.

A child will experience tremendous difficulty in knowing what a man is like if no man is available to be seen in action, to be felt, to be heard. The daily pattern of one's early years set the stage for one's expected view of the world. That future world will necessarily include men. It is imperative that the child obtain an in-depth, steadily portrayed picture of a man in order to relate satisfactorily with future men. Father is every bit as important as mother. Don't forget it, father. Don't let anybody sell you short.

Sometimes I think that the most common defect in fathers today is insufficient toughness. This does not imply that Dad should be a snarling, horsewhip-brandishing ogre. I do mean that he should pay less attention to advice that suggests he be a mealy-mouthed pacifist, or a kind of insecure negotiator. Love and personal involvement, certainly; nothing blossoms without these. All modes of expression should be so deeply permeated with love and the love, itself, is never an issue. But enough of love; love alone won't suffice.

Needed Quality of Toughness

Toughness in the sense of resoluteness, of steadfastness, of firmness. Toughness in persevering in that effort which is difficult; in wrestling in a hard struggle, not sure of the outcome, but still with the fortitude to fight. Our culture badly needs this quality. Our children can hardly get it anywhere except from fathers.

A man, hamstrung by ineffectuality in many areas of his functioning, told me, "I was never really forced to undertake anything hard. I grew up learning that assertion was bad. Consequently, I never had the satisfaction of a victory won against odds; instead I learned techniques of evasion." He felt self-depreciation; the cup of life was flat.

Men who lack vigorous fathers usually fail to define in themselves that which is manly. Mothers, with all their marvelous contributions to good character traits in their child, still should not appear Herculean. Parents are customarily viewed as gods by their children (for a brief while, anyway), but mother should not be too powerful — that's the role for father. Woman's essential femininity is impaired if she is too strong. The roles of father and mother are of equal importance, but the paths of expression of each are quite dissimilar. For the good of everybody, including himself, father should be the symbol of strength.

Children too closely identified with mother frequently suffer from an inordinate fear of failure. One has to learn that, in actuality, mother's milk is not forever available — surely one of life's more cheerless discoveries. Women, by their inherent passivity, cannot readily inspire the ability to roll with a punch and then arise for new battle. Self-reliance and optimism are necessary to handle the failures that one meets. If ill-prepared for defeat, then one's failure becomes abysmal, stultifying. The campaign is lost after the first unhappy skirmish. Not that we are interested in rearing citizens comparable to the defenders of Thermopylae, but we do wish our children to be able to meet reverses. This ability must be learned somewhere. Here again, the undaunted purposefulness of a father is vitally required.

Mother Must Push

In general, father should supply the drive, the go-ahead, the push, the out-of-the-home strivings for the family. His is the task to launch the child upon the long road that leads, ideally, to relative maturity. Father helps the child gradually loosen the soft ties of dependency; no weak man can do this successfully, for the ties,

*Dr. Brown, a Mobile Psychiatrist, is a frequent contributor to the Journal.

though soft, are many and sinewy. People whose fathers were not able, for whatever reasons, to lead them away from the home often lack social poise. They are shy, less verbally communicative, uneasy with others, stumble through social intercourse painfully and all the while curse their own awkwardness and thus depreciate themselves further.

Mother, in turn, is the great nurturer. Her sphere of influence is more geographically limited, but within this green refuge (her home) she performs daily the miracles of taking-care-of. The absolutely intimate items of food preparation, clothing, beautification; the consoling caress, the loving solicitude without which few wounds heal well—these are her gifts. She shelters, protects; she resists the gritty inroads of the world. It is she who whispers, "Stay—venture not away, for outside lurk dangers. Stay where love, and warmth, and beauty breathe always for you." She is, of course, entirely correct in her estimate of the situation. For she knows that her best faculties can never equip her to struggle with the world outside her home. She rightly mistrusts this external life, and cleaves to that which she knows is *her province*. She keeps the flame in the temple bright; she does not gladly search the dark forest for kindling.

Father and mother, thus, have vital parts to play. But the lines of their parts are different, their attitudes and behavior are different, and their ultimate effect on each other and their offspring must be different. I wonder if this distinction is always kept straight. I am concerned lest occasionally parents are misled into thinking that they can step into each other's shoes. For example: men complaining that wives do not understand the conflicts and labor that beset the husband in his daily toll; women who are irritated or saddened because husbands do not equally share wife's pleasures and attention to details of home beautifying. Quibblings, even deep misunderstandings over such issues are common. This is about as reasonable as expecting husbands to enjoy embroidering, or wives to thrill over big-game hunting.

Wives occasionally berate husbands for their apparent lack of interest in their children's education (especially in the grade-school). Granting that some fathers are too disinterested in this facet of their children's lives, still it should be clearly understood that the early education of the child comes principally under the large heading of nurture, and so belongs mainly to mother. As the child grows older, father, sensing the increased ranging away from home of all of the child's activities, often engages himself more in the educational endeavor. But trying to get fathers of early grade children as much involved in P.T.A. work as are mothers is a plain misconception of the roles of parents.

Role-Alterations

Our culture is often blamed for many behavioral postures. Without trying to define the responsible elements, I think that our society does much to foster the increased passivity of men and the increased activity of women. I believe that 99% of all such role-alterations are categorically detrimental to desirable character formation — in the individuals themselves and in the people who live with them. No wishy-washy, leave-the-decisions-to-mother man gets much respect, even from himself; no assertive, briskly efficient woman inspires feelings of loving protectiveness in anyone.

Our world holds a great diversity of recreational opportunities, thousands of gadgets, almost instantaneous global communication. We contact a greatly increased number of people, or ideas, of sights and sounds and experiences. Children, particularly, are presented with too-wide avenues to explore, too many toys. Often the result is that *no* avenue is fully traveled; nothing is ever truly begun, worked on, and finished. The lesson of encountering, mastering, and usefully developing some technique is not learned well. If this toy, or this idea doesn't please, forget it, pass on to the many others that flash rapidly before us. One's view of the world becomes bland and fragmentary, with no need to stop the swirling picture.

Father must function as the prime focusing agent. His firm hand stops the tumbling images; he says, "This we shall do, and do competently, before we proceed." The traditional task of organizing, directing, bringing continuity to the task undertaken — this father must do. The bent nail needs re-driving, the gun oiled, the birthday remembered. A promise given is a promise kept. Father is positively required to be a sensitive filter between his family and what Santayana termed "the furious and indiscriminate cataract of life." No one—absolutely no one—but father can do this. Children require this from him, so does mother. How often, on Sunday afternoons, does mother ask, "What will we do today?"

Father says, "I don't care. Whatever you want."

And she replies, "That's just it — you never want to do anything."

This minor dialogue reflects a wife's need of guidance, of positive leadership, of enthusiastic direction — and of her exasperation when such is not forthcoming.

Wives Need Men

Decisiveness, reliability, enterprise and self-reliance, enthusiasm, and courage—no family lacking an adequate father has enough of these qualities. All mothers with inadequate mates are fearful. This fear may not be openly expressed as such; it may be cloaked in various guises, manifesting itself as easily aroused resentments, a pervasive feeling of anxiety, or in other troublesome patterns. A wife is like a person walking into a dark room: she needs the solidity of a known object to guide her uncertain steps. She needs husband's calmness, his strength, the known assurance that he is going to handle whatever arises.

Mothers, partly because of their greater contact with their children, often generate considerable hostility (even if unconscious of this) towards them. Here again, father's steady composure is an invaluable buffer for these hostilities. Frequently seen is the mother who expresses undue concern over the well-being of her child, who shows a querulous fussiness over his every move. She is anxious and hostile; without a firm husband to allay and absorb some of these conflicts she flounders. She requires husband's strength to guard her against her own (unconscious) fears of lack of control over her impulses.

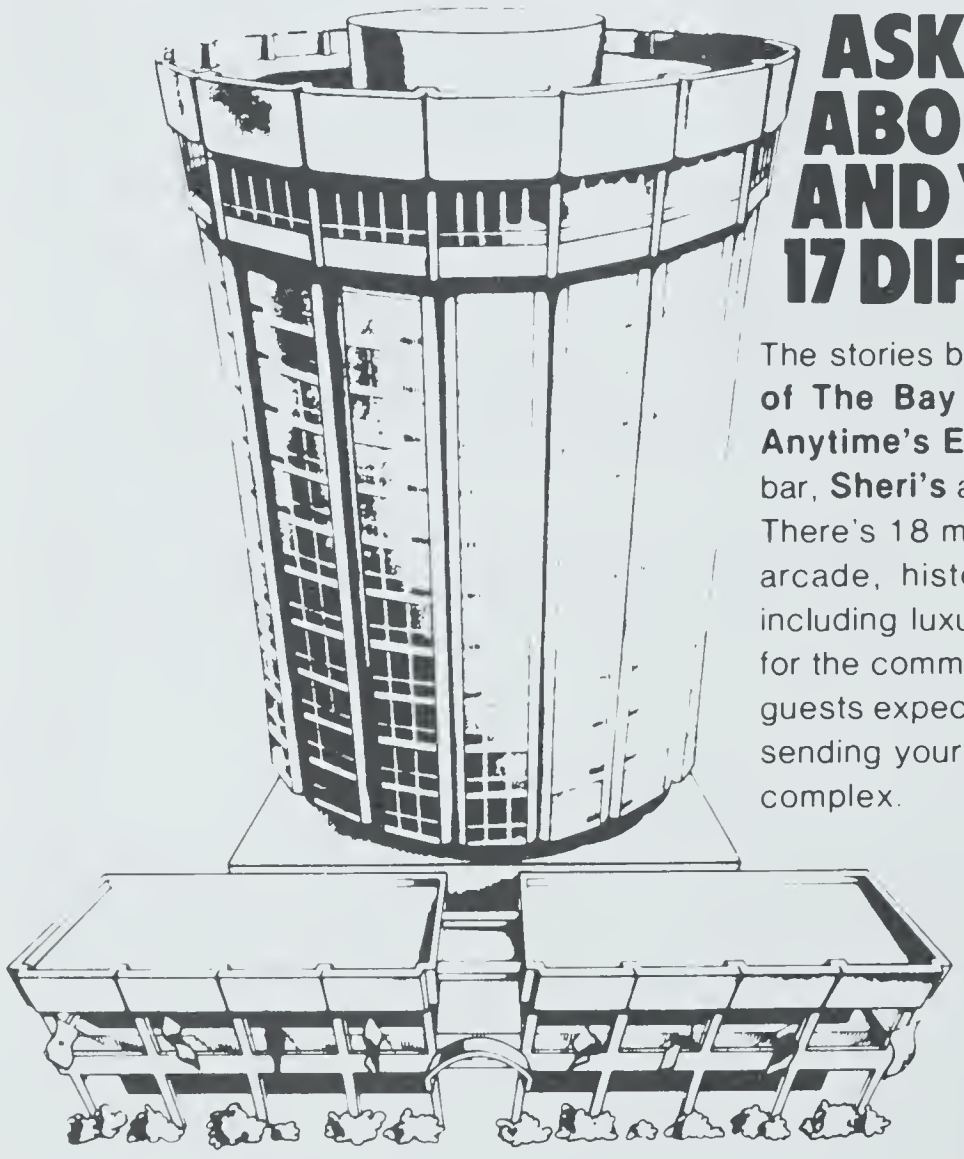
Aside from such internal problems, mother wants father's backing and suggestions in many of the ordinary issues of household management. Raising children properly is the world's hardest task, bar none — it is also the most rewarding. Mother meets many situations that cause doubt in her: what to do about the teacher's remarks, decisions pertaining to punishment, strife with neighbor children. Also, what to do about the washing machine, the furnace, and all the other recalcitrant appliances. Dozens of issues, insignificant singly, yet their total weight is large. She needs assistance; often the main assistance she needs is a definite answer from a person who genuinely shares her feelings. That's you, father. Substitutes are far less satisfactory. Give her an answer—yours is the very best she can get!

Father, face it and rejoice! Mother and children cannot flourish without you. No matter how much the superficial protests from the family, no matter all the external pressures that foster greater domineering strivings from mother—*you've* got to be boss. If you're not, the team is weak.

Of course, if father is able to do so, he must work. Constructive and regular employment, in our United States, is a prerequisite for a man's self-respect. Esteem can never be bought; it can only be earned. In addition, economics force most men to work. Work usually takes father away from the home. The time that he does spend at home, therefore, becomes even more important. Fathers sometimes lapse into such loose thinking as, "I work hard at the job all day. When I come home I expect some peace."

What Are You Working For?

He's partly correct in this attitude; after all, home is supposed to be the comfortable cave to which he returns after battling the storms and the saber-toothed tax collector. But he's also partly wrong; he's saying, in effect, that after his toil in the salt mines he is now ready to fling himself into a dependent, disinterested position and be waited on — detached, licking his wounds, cherishing his own self-preoccupations. A balance needs to be struck between these extremes. Wife and children need far more than the money that he earns.



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They need *him*. They clamor for his attention, his words and caresses, his wisdom and direction. What else, man? What are you working for?

A sharp little girl, listening to her father moaning about his miserable day at work, speared him as she said disgustedly, "So you went to work today — What do you want, a medal?"

Our urbanization makes it even more urgent that father devise projects that he and children work on together. These jobs should often involve physical activity, for father should be seen as a man in action, doing and creating. He is the teacher of technique, especially to the son. Carpentry, painting, repair jobs — simple enough, but the task has, in addition to its own homely justification, a far more valuable function: it is the vehicle for a creative experience. The observation of a new skill, the learning of this with a loved person, and the eventual mastery of this skill for one's self — this is growth. This is expansion of the ability to order and control a bit of the world. This is part of the early beginnings of the Grecian concept of self-development, a cornerstone of maturity.

Both boys and girls need to know that father is a strong animal. "Animal" is used deliberately, to convey the physical nature of father. Every individual maintains a life-long interest in his or her own body. "Anatomy is destiny," wrote Freud. Children should learn early that one's body, like one's intellect is to be used to the fullest in the best expressions of self. They must know from the models presented to them that there is nothing pertaining to the body that is evil or disgraceful. Father's strength and agility, however expressed, should be sources of gratification to him. His children need to know that he enjoys physical sensations: pleasure at the touch of a breeze, a fast pitch deftly caught, the heave of the deck in a rolling sea.

Further, one's body is a modality in the expression of love — and we must learn how to express love. Father's manifestations of affection should be clearly visible: his caresses, his touch. If he inhibits the outward signs of his interest, children are apt to assume that there is something inappropriate, shameful about such physical relating to others. Children should not sleep with parents, or in parents' bedroom, but they should know from less intimate observation that father is interested in mother as a woman, an entity — that he enjoys touching her, being close to her. Other aspects of father's regard for mother, such as his protectiveness and tenderness, are part of his general attitude towards women; these qualities will be subtly conveyed, too. Daughters must learn — and can only learn this from fathers — that women are eminently desirable as wives. Father should also love God, bullfrogs, sunsets, even dolls.

Speak Up

Father, probably more than mother, tunes in the emotional wave-length on which the family lives. If he is glum and cold the home can hardly be bright. Not that he should be a congenitally cheerful goof, but he should occasionally sing and joke; he should also fuss a bit if he feels like it, speak in a loud voice if driven to do so, and, in general, express as much *positive feeling* as he can. For enthusiasm is a priceless trait. Father has to *like* doing, feeling, thinking.

Women, again from their intrinsic personality structures, need encouragement, a source of zestful drive. Father's interests tend to become those of the family; if he has no interests it's hard for the family to lift itself out of staleness. The world is constricted, less colorful. His is the hand that paints a larger canvas, in brighter colors.

With their many wonderful attributes, women are not philosophers. Neither are most men, which is probably all right. Men do possess a greater ability for abstract thinking than do women. (This does not imply that men think *better* than women; they just think *differently*. Women, for instance, are many times more perceptive than men, and form intuitive value judgments of people far more accurately than do most men.) Intellectual stimulation from father should complement that from mother.

How does he show this different orientation? By how much time is devoted to specific items (if he spends more time whittling than he spends reading, presumably whittling is more fascinating); by the words he uses to indicate his involvement; by the feeling that he conveys (tone of voice, imaginative enhancement, images and parallels drawn). Also, by the exercise of his planning ability: to conceive projects and execute them; to demonstrate the whole emerging from the single part; to visualize the potential enjoyment and success that may spring from a small seed. Again, a man is the enthusiastic planner, the trail-blazer, the disciplined leader. If father wishes his child to be aware of the "life of the mind," then father has got to show his own interest in something other than TV, that gentle usurper of the intellect.

Fathers, perhaps due to the changing working role of women, but due also to other less obvious influences, sometimes depreciate their roles. They find less joy in their own work, and less respect in their homes. They are not entirely to blame, for our society, with its pervasive encouragement of a regressive dependency and its penalization of creative self-assertion, lays a deadening hand on individuality. But father need not wrap this stifling mantly too closely about him; to do so is abdication of responsibility by him.

In him the concepts of loving firmness, protectiveness, initiative, and determination must coalesce into a meaningful whole. In him, as in no one else, must his loved ones see this steady pattern, the predictable response. His strength of muscle and of purpose; his discipline (not punishment, but instructed leadership); his loyalty and keen concern and warmth — are all such burning requirements from his family that no home, nor even his own heart, can glow without them.

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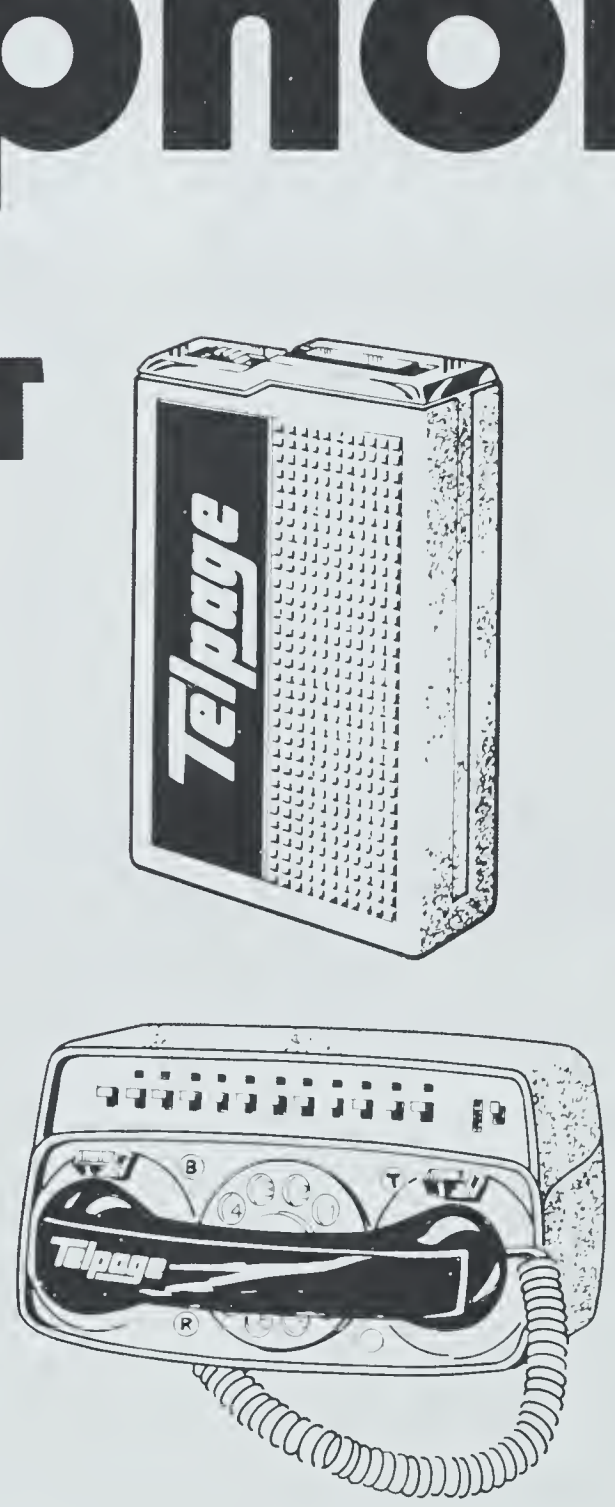

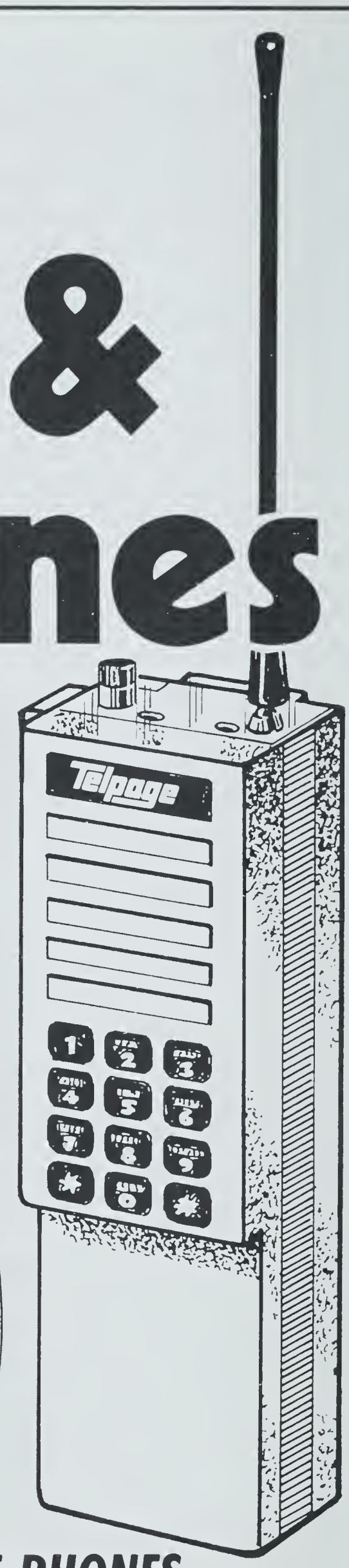

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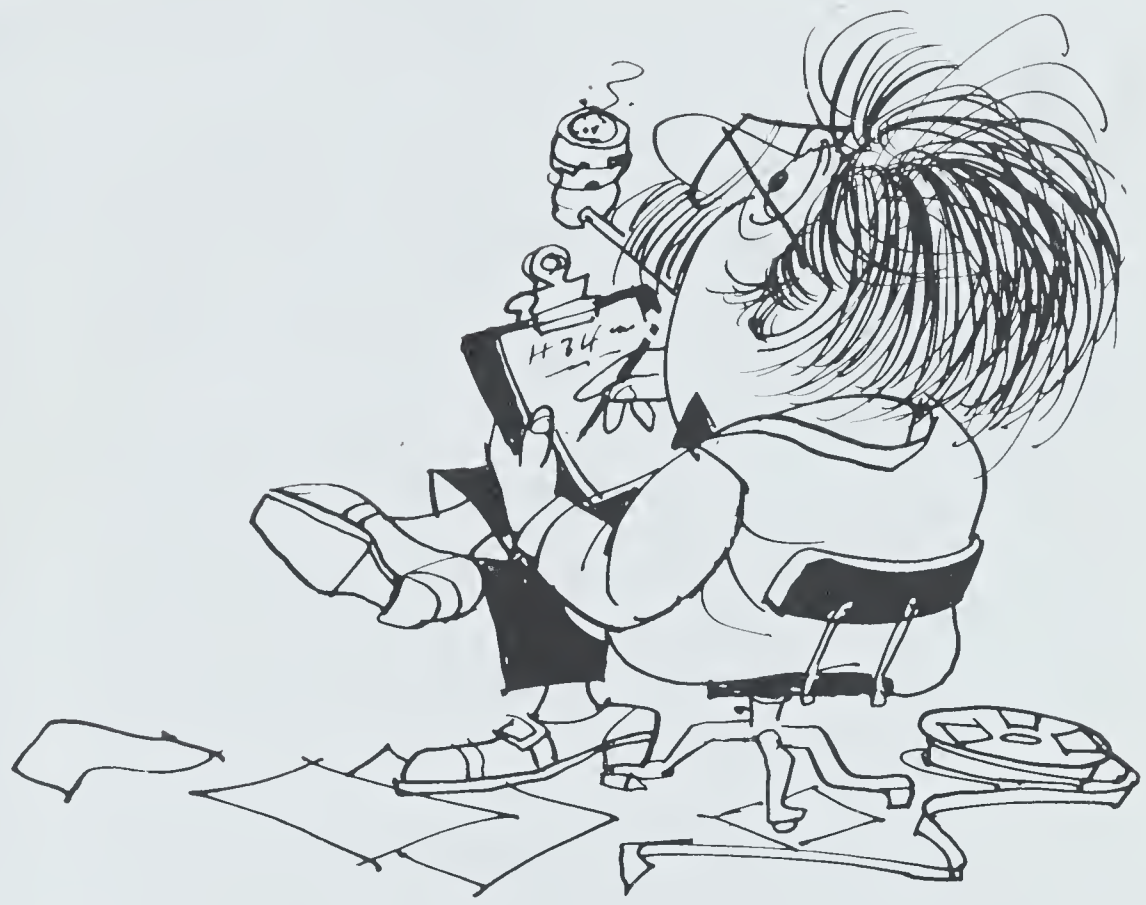
Scientists Prove Science Writers Cause Cancer



Gerald Weissmann, M.D.
IN HOSPITAL PRACTICE

Bay State City, September 29, 1981. Scientists from the Bay State School of Public Health have obtained strong clinical evidence that exposure to science writers is associated with cancer of the lip. A five-year retrospective study using the case-control method has shown that patients with lip cancer had read the reports of science writers much more frequently than had patients of an age-matched control population treated by the same physicians for canker sores.

Reporting for his group of 13 scientists and a typist, Dr. Hyatt Regency, Atrium Professor of Epidemiology at Bay State, was quick to point out: "We have shown an association between a common human tumor and an unusual avocation. Although no direct cause-and-effect relationship has been established, our studies suggest that it may be prudent for many Americans to curb their voracious appetites for news of environmental carcinogens."

The report, to be published tomorrow in the prestigious *Bay State Journal of Medicine,* was based on questionnaires distributed to 3,256 patients treated for cancer or other conditions by doctors attached to the otorhinolaryngology services of various hospitals in the Bay State City area. Otorhinolaryngology is also called "ear-nose-throat" by doctors and ENT by patients. Cancer is a very bad disease. Hospitals are poorly run hotels where doctors work and patients pay.

Dr. Weissmann is Professor of Medicine and Director, Division of Rheumatology, New York University School of Medicine.

The professor explained that although the research group did not actually examine the patients, they carefully evaluated the results of the questionnaires by means of an Apple computer. A computer is an electronic device that generates scientific papers. An apple is a fruit.

The study in question has shown that patients with cancer of the lip were 3.5 times more likely to have read science writers' news reports of articles originally published in prestigious journals than were the patients in the control group. The patients were asked: "Have you read a report by a science writer within the last two months?" and "Can you remember his/her name?" Five percent of each group answered the first question; only two patients answered the second, recollecting articles by Eunice Shriver and Francois Mitterrand. Dr. Regency admitted that his team had considered the possibility that the data may have been skewed by the controls chosen: "However, I do not believe that the control patients with canker sores failed to read newspaper articles on science because they could not move their painful lips." Cancer of the lip is painless.

He went on to say: "We were surprised at the results of this study, which was actually designed to test the theory that there is an inverse relationship between human intelligence and stuffy sinuses." Speaking between sneezes, Dr. Regency expressed gratitude for the funding of this work by the National Endowment for Sociobiology and the Earl of Olay.

At his weekly scheduled news conference, Dr. Avery Podhoretz, editor of the prestigious *Bay State Journal of Medicine,* distributed preprints of the

breakthrough research report to this reporter, as well as to representatives of the *New York Times,* the *Washington Post,* the *Los Angeles Times,* and the *Falmouth Enterprise.*

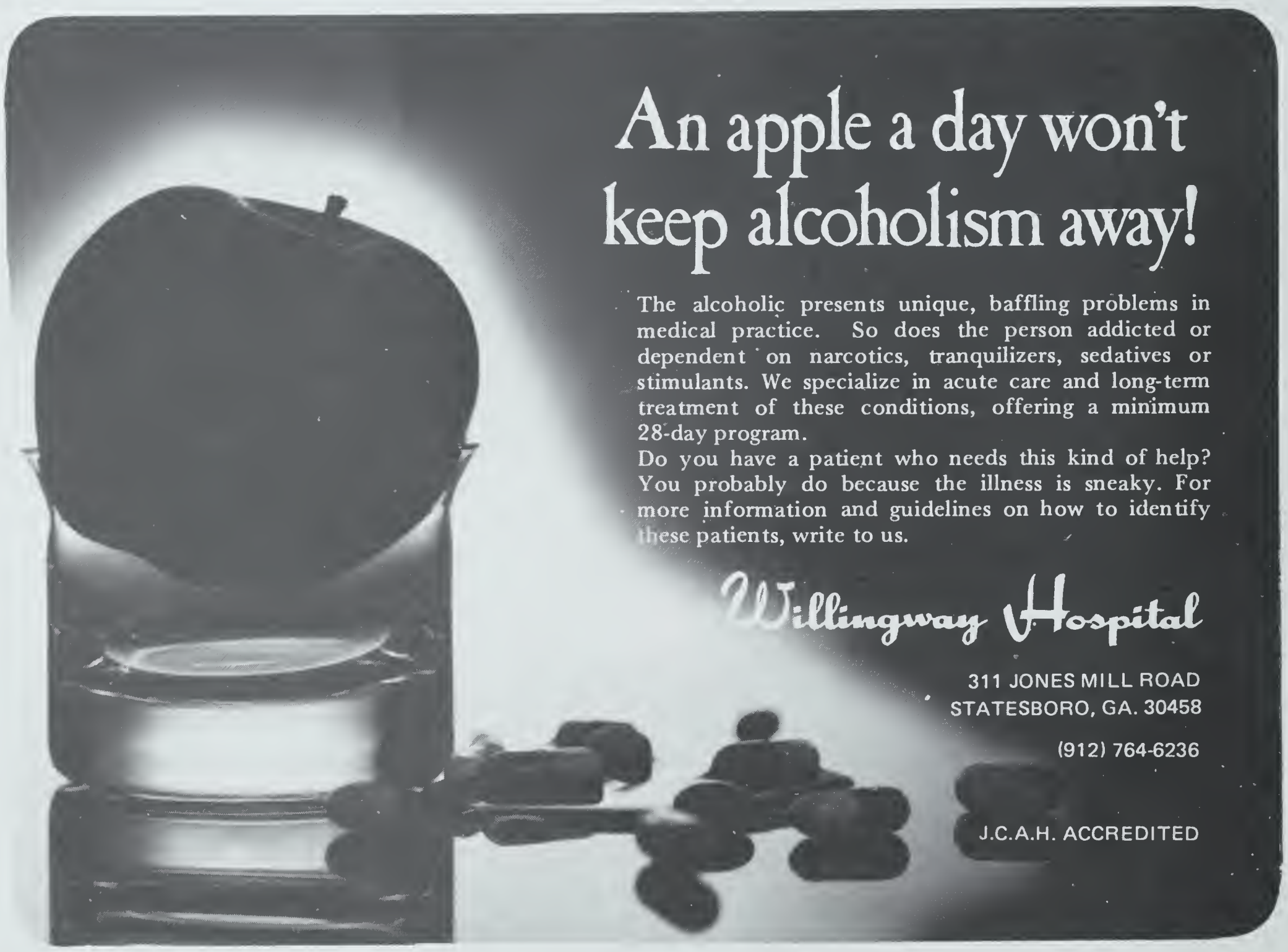
He pointed out that the case-control method was the chief method used to establish links between cancer and personal habits, at least in prestigious journals, such as his. The case-control method, he explained, has previously shown statistically significant associations between cancer of various organs and ingestion of coffee, tea, scotch, bourbon, salt, pimientos, and egg creams.

"Prestigious journals," said the editor, "the kind you see quoted in the *New York Times,* the *Washington Post,* the *Los Angeles Times,* and the *Falmouth Enterprise,* play a major role in informing the public as well as physicians. If the practicing doctor cannot explain to his patients the well-publicized contents of a prestigious journal which will reach him tomorrow, let him wait at the post office to intercept his issue. It is unethical for prestigious journals *not* to disclose their contents in the press or on television."

Both Drs. Regency and Podhoretz illustrated the usefulness of the case-control method by referring to a classic Danish study by H. C. Andersen. Andersen questioned 3,256 storks in a retrospective, five-year case-control study. It turned out that significantly more storks had nested on the roofs of houses that had recently been blessed by newborn babies than on the roofs of houses without children. Although Andersen was not able to exclude the possibility that storks preferred the warm roofs of multibedroom cottages over the hovels of the single or childless, it was this pioneering study (also published in a prestigious journal) that first drew attention to the now well-supported epidemiological evidence that storks bring babies. Babies are small humans. Storks do not publish in prestigious journals.

"With research support becoming more difficult to obtain," Dr. Regency avowed, "it is exactly this sort of simple, old-fashioned science that will now come into its own. Anyone can run a desk-top computer, and questionnaires are less expensive than electron microscopes." An electron microscope is more expensive than a questionnaire.

Replying to questions as to *how* the reading of science writers might produce cancer of the lip, the doctor suggested that this problem remains for future investigators to solve. "Besides," he added, "prestigious journals will not print hypotheses—only facts." Facts are printed in prestigious journals.



Will Alabama's Children Survive in the 80s?

by
Beverly W. Boyd, M.D., Director
Bureau of Maternal & Child Health/Family Planning

Before any evaluation of the future health of Alabama's children begins, we should recognize the significant achievements in child health that occurred over the past 10 to 15 years. One of the most important of these developments has been the significant reduction in infant mortality that has occurred both in the United States and in the State of Alabama.

From 1964 to 1979, the United States' infant mortality rate declined from 25 deaths per 1,000 live births to 13 deaths per 1,000 births. Over this same period of time, Alabama experienced a decline in its infant mortality rate to 14.3 per 1,000 live births, which is the lowest rate recorded in the state. Over the past decade, there has been a 40% decrease in the infant mortality rate for the State of Alabama, with a 39% decrease in the rate for whites and 45% decrease in the rate for non-whites.

In 1979, the infant mortality rate was 11.3 per 1,000 for whites and 19.5 per 1,000 for non-whites. The introduction of effective maternal and infant care programs in low income areas and the improved nutrition and better social services that many times accompany these programs have certainly had an important role in this overall decline in the infant mortality.

A second important development that has occurred has been a change in the causes of illness and death in children. For many years the major threats to the health of our children were infectious diseases, nutritional deficiencies, and gastrointestinal disorders. The development of immunizations against many infectious diseases and the availability of better medical services have brought most of these diseases under control.

In the year 1980-1981, 72% of the two-year-olds in Alabama were totally protected from measles, mumps, polio, diptheria, whooping cough, and tetanus. Ninety-eight percent of children entering school in 1980-81 were fully immunized. As a result of these scientific advances, the major threats to our children today are birth defects, accidents, violence, and malignancies.

Birth Rate Sinks

A third important development has been a general decline in birth rates both in the United States and in the State of Alabama. Since 1947, Alabama's birth rate has shown a downward trend. Periodic increases have occurred, but the general pattern has been one of a decline. In 1979, Alabama's birth rate increased slightly from 16.1 to 16.5 per 1,000 population. Both white and non-white fertility increased during that year, with the birth rate for whites being 14.1 and the non-white birth rate being 23.7. The availability of family planning services, the growing trend by young people to postpone having children, and public concern over population growth have all had an influence in this general decline. This decrease in birth rate has important implications in terms of looking at the numbers of children that will need health care in the coming years in Alabama.

A fourth important development that has occurred over the past decade has been the generally improved educational level of our population. One of the most important factors associated with increased life expectancy is literacy. More and more of the problems that occur during the rearing of children can now be managed directly by literate, comparatively well-educated parents. A 1976 National Survey by Child Trends, Inc., found that parental education was many times the best predictor of the child's vocabulary, school performance, practical skills, behavior, peer relationships, and level of fears and worries. The role of education in child health care will certainly become more important in the future.

A fifth important development has been an overall trend toward improved housing and improved nutrition. This has had a favorable effect on child health. Most children in the United States live in housing with piped-in pure water and complete indoor plumbing facilities. However, there are still significant numbers of children in Alabama who do not have this protection. Also, many communities in Alabama do not have fluoridated water supplies to prevent dental cavities.

Shrinking Families

And finally, there have been dramatic changes in the structure of the family that have influenced child health. The average size of the American family has been steadily decreasing since 1970. Nationally, 50% of children below age 18 have mothers who are employed or who are seeking employment. Southern women have always participated in the labor force at a greater rate than women who live in the non-south. Approximately 48.5% of all southern mothers with preschool children work outside the home. Black children are more likely to have working mothers than white children.

Another trend has been the rise in the illegitimacy ratio over the past 25 years. In Alabama, the number of

illegitimate births continued to rise in 1979, when we had an illegitimacy ratio of 218.8 per 1,000 live births. Among the age groups, 15-19 year old mothers produced the greatest number of out-of-wedlock births. The risk of low-birth-weight infants and the subsequent medical complications is much higher in illegitimate births, and this is an important factor in child health.

Because of these six developments that we have seen over the past 10-15 years, a new set of child health problems has appeared. One of the most important of these problems is teenage pregnancy. Alabama has the third highest rate of teenage pregnancy in the United States. Approximately 8% of all teenage girls in the state have babies every year. Many teenage mothers are single. In Alabama, the illegitimacy ratio for mothers under 15 is 857.5 per 1,000 live births. For mothers aged 15-19, the illegitimacy ratio is 487.9 per 1,000 live births. The probability that the teenager who becomes pregnant will drop out of school, end up in proverty, become divorced if she marries, have a major medical complication, or die during pregnancy is increased several times over that of women who wait until their 20s to have children.

Babies born to teenage mothers have a much greater likelihood of being premature, having handicapping conditions, being mentally retarded, or dying. It is clear that one of the most important things that professionals and families and communities can do over the coming years is to prevent teenage pregnancy. Many teenagers are making a decision to have intercourse before they are physically or emotionally ready, and unfortunately there are large numbers of teenagers who do not even really make a decision about sexual activity but rather allow it to "just happen".

One of our first efforts should be to discourage early sexual activity for our teenagers and provide them with information which helps them make a decision to say "no" to early sexual activity. For those teenagers who decide to become sexually active, we must provide them with the information and contraceptive services that they require. More than 20,000 teenagers use the State Health Department system for preventive contraceptive services each year. We estimate that at least 8 to 10,000 teenage pregnancies are prevented through this system of contraceptive services each year. A related problem is the marked rise in the incidence of sexually transmitted diseases, especially gonorrhea, syphilis, and herpes virus. Services for sexually active teenagers should certainly include efforts to control venereal disease through screening and case-finding, and through prevention.

Drug Abuse

A second problem which has now become a major concern for adolescents is drug abuse. This includes abuse of alcohol, tobacco, and narcotic medications. Alcohol continues to be a widely abused substance, and recent national surveys conducted by the National Institute on Drug Abuse have shown trends of alcohol use among adolescents. In a senior high school class in 1977, more than 90% of the students responding had tried alcohol at least once; 71% had used alcohol within 30 days of the survey; and, most distressing, 6% reported a daily use of alcohol.

It was found that about one half of adolescents, ages 12-17 years, had tried alcohol, and 31% had used alcohol within 30 days of the survey. The long-term effects of alcohol consumption are widely known and they include liver damage, nutritional deficiencies, brain damage, emotional changes, inability to hold a job, and poverty. Police records show that nearly one-half of all arrests are alcohol-related. Babies born to women who drink heavily, develop a syndrome of problems which include low-birth-weight, congenital anomalies and mental retardation.

However, the most important immediate risk to the adolescent from alcohol use is death or serious physical injury, including paralysis, caused by driving under the influence of alcohol or by riding with a person who is driving under the influence of alcohol. Accidents are the principal cause of death in the 15-19 year age groups and alcohol is many times an important factor in those accidents. Parents should be encouraged to set limits on alcohol consumption, and professionals in the community should discourage adolescent drinking.

Smoking Adolescents

Another important health problem for adolescents is cigarette smoking. We have had good evidence for many years that cigarette smoking is responsible for 325,000 early deaths each year from cancer and diseases of the lungs, heart and circulatory system. About 90% of lung cancer cases are related to smoking. Thirty percent of strokes and other blood vessel diseases; 75% of bronchitis, and 80% of emphysema in the United States is related to cigarette smoking. Despite this knowledge, teenagers continue to smoke.

In 1979, 13.5% of boys and 11.8% of girls age 15 and 16 regularly smoked. For teenage girls, the incidence of smoking has actually increased. The decision of whether or not to smoke will have important consequences on the future health of our children. Health education efforts should be directed to prevent smoking and to persuade current teenage smokers to quit.

Abuse of marijuana and narcotic medications can also create problems during adolescence. More than 15% of the general population has had some experience with marijuana. Adolescents may limit drug abuse to special occasions and parties, or they may be abusing drugs on a daily basis. In 1977, 10.7% of high school seniors surveyed admitted smoking marijuana daily. Heavy drug use can lead to behavior problems, poor school performance, health problems, and inability to hold a job.

Probably the most important problem for adolescents is accidents. Accidents are the leading cause of death for ages 1-14 years, with automobile fatalities being largely responsible for the high accident rate. Among adolescents ages 15-19, death rates decreased nearly 2% per year from 1950 to 1960 and then increased at about the same rate during the next ten years. From 1976 to 1977, the death rate for teenagers 15-19 years of age increased by 5%.

Over this period of time, motor vehicle accident deaths increased 4%. Many teenagers killed in automobile accidents are either drivers or passengers, and efforts to prevent these deaths must include education on responsible driving decisions, improved safety for automobiles, and reduction of speed. Pedestrian-automobile deaths are also important, and bicycle safety, emphasis on careful crossing of streets, and driver awareness of pedestrians should be included in prevention efforts.

Violence as a Health Factor

A fourth important problem for adolescents is violence. From 1976 to 1977, the death rate for teenagers ages 15-19 from suicide increased 20%. Homicide is one of the top five causes of death for children in the United States. Child abuse may be responsible for more than 5,000 deaths per year nationally. Little is known about how to effectively deal with increasing problem of violence in our society, but the costs to our children demand that we begin to seriously address this issue.

Many people today view health problems as life style problems, and the life styles that our adolescents adopt will have important consequences on their future health. The decisions that teenagers make about their diets and the amount of exercise they participate in will in some ways determine the health status they experience in the future. Adolescents need encouragement to pursue physical fitness and physical training and to make that training the beginning program of physical activity. Many adolescents have very poor eating habits and are more concerned with the appearance of their bodies than with the actual health of their bodies.

Information and counseling on intelligent food choices will help adolescents to begin a life time program of a good diet and avoidance of obesity and its subsequent health problems. Studies by Brewlow and Belloc of nearly 7,000 adults followed for 5½ years have shown that certain common habits of daily life, called good health habits, are positively related to physical health status. These basic health habits are three meals a day at regular times and no snacking, breakfast every day, moderate exercise two or three times a week, adequate sleep (seven or eight hours a night), no smoking, moderate weight, and no alcohol or only in moderation.

Mortality as measured by age-adjusted rates, was more strongly associated with poor health habits than with health status or income level. This is further evidence that the true health problem today is the way we live and adolescents should be encouraged to begin practicing good health habits.

The environment continues to play a large role in health in the United States. Advances have been made in improving housing, ensuring safe water and adequate sewage disposal, controlling toxic substances and pollution, and in preventing lead poisoning in children. These efforts should be continued, but perhaps the most important change in environment that we can make for our children is the alleviation of poverty.

Forty percent of our nation's poor children live in the South. While the poverty rate for children declined in the 1970s, most of the decline was for white children, with the poverty rate for black children remaining fairly stable. Almost 20% of southern children have no medical cost protection—either private insurance or Medicaid. This is significantly higher than the average rate for the United States of 12%. We must place a high priority on alleviating poverty if we are to truly meet the developmental needs of our children and their families.

Illiteracy Continues

Education is rapidly becoming a major determinant of health in the United States. While our overall educational levels have improved, illiteracy remains a problem for as much as 20% of our population. During the year 1975 to 1976, for every 100 high school graduates in Alabama, there were 30 students who did not graduate from high school. Lack of knowledge should not become a barrier to good health for our adolescents. Our children must be encouraged to finish their education, and our school must provide students with a sound foundation in reading and health education as well.

In summary, the seven major problems that adolescents will most likely face in the future are first, the problems of adolescent sexual activity, pregnancy and venereal disease; second, abuse of alcohol, tobacco and other drugs; third, accidents; fourth, violence; fifth, life-styles; sixth, environment, and seventh, education.

What should our strategy be for assisting our adolescents in dealing with these seven major health problems? First, we must all begin to recognize that personal choice health behavior is an important component in each of these seven problems. Most adolescents do not even worry about their health until they lose it. We must assist our children in developing an individual responsibility for their own health. This is difficult both because we know very little about changing behavior and also because most people in our culture live day-by-day rather than planning for 10 years from now or 20 years from now.

Everyone is a gambler and knows someone who has done all the wrong things and lived to be 100. Helping our adolescents to make responsible personal health decisions will not only affect their health but will also

have important consequences for the health of their children. They are our future parents, and they will have significant responsibilities for the health decisions made for their own children.

A second important strategy will be the organization of health services of our children. Seventy-two percent of all infant mortality in the South occurs in babies less than one month of age. Prenatal care occurring early in pregnancy, prevention of unwanted pregnancies, availability of perinatal care, and the availability of programs to improve the nutrition of mothers are all important in reducing infant mortality. Health services need to be designed to meet the health needs of adolescents, including contraceptive services, services to prevent and treat venereal disease, services to prevent and treat drug abuse, and appropriate health education in responsible life styles and accident prevention. These appropriately designed services should be available to adolescents regardless of financial ability to pay for these services.

And, lastly, the community must recognize those important problems that are beyond the total control of the individual. The problems of violence and the environment are certainly community issues and require an organized, coordinated approach on a local level.

The answer to our question "Will Alabama's Children Survive the 80's?" is contingent on the efforts of parents, adolescents, and the community in the above mentioned areas of personal choice health behavior, organization and delivery of health services, and community organizations. Our challenge over the next decade will be to develop effective approaches to these problems and to implement them in an effective manner.

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Bronchitis ond pneumonio coused by *S. pneumonioe* (formerly *D. pneumonioe*)
Otitis medio coused by *S. pneumonioe* (formerly *D. pneumoniae*) ond *H. influenzae*
Acute exacerbotion of chronic bronchitis coused by *H. influenzae**
*Though clinicol improvement has been shown, bocteriologic cures connot be expected in oll potients with chronic respiratory diseose due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections coused by Group A beto-hemolytic streptococci ond stophylococci, non-penicillinose producers.
URINARY TRACT INFECTIONS coused by *E. coli* ond *P. mirobilis*. (This drug should not be used in ony *E. coli* ond *P. mirobilis* infections other thon urinory troct.)
NOTE: Perform cultures ond susceptibility tests initiolly ond during treotment to monitor effectiveness of theropy ond susceptibility of bocterio. Theropy moy be instituted prior to results of sensitivity testing.
Contraindications Controindicoted in individuols with history of on ollergic reoction to penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use of ontibiotics moy promote overgrowth of nonsusceptible orgonisms. If superinfection occurs, toke oppropriote meosures.
PREGNANCY: Pregnoncy Cotegory B. Reproduction studies performed in mice ond rots ot doses up to 10 times the humon dose reveoled no evidence of impoired fertility or horm to the fetus due to cyclocillin. There ore, however, no odequote ond well-controlled studies in pregnont women. Becouse onimol reproduction studies ore not olwoys predictive of human response, use this drug during pregnoncy only if cleorly needed.
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Adverse Reactions Orol cyclocillin is generolly well toleroted. As with other penicillins, untoword sensitivity reoctions ore likely, porticularly in those who previously demonstroted penicillin hypersensitivity or with history of ollergy, asthmo, hoy fever, or urticorio. Adverse reoctions reported with cyclocillin: diorrheo (in opproximotely 1 out of 20 potients treoted), nouseo ond vomiting (in opproximotely 1 in 50), ond skin rash (in opproximotely 1 in 60). Isoloted instonces of heodoche, dizziness, obdominol poin, voginitis, ond urticorio hove been reported. (See WARNINGS) Other less frequent odverse reoctions which moy occur ond ore reported with other penicillins ore onemio, thrombocytopenio, thrombocytopenic purpura, leukopenio, neutropenio ond eosinophilia. These reoctions ore usuolly reversible on discontinuotion of theropy.
As with other semisynthetic penicillins, SGOT elevotions hove been reported.
As with ontibiotic theropy generolly, continue treotment ot leost 48 to 72 hours after potient becomes asymptomotic or until bocteriol erodication is evidenced. In Group A beta-hemolytic streptococcol infections, ot leost 10 doys' treotment is recommended to guard ogoinst risk of rheumotic fever or glomerulonephritis. In chronic urinory tract infection, frequent bocteriologic ond clinicol opproisal is necessary during theropy ond possibly for severol months ofter. Persistent infection may require treotment for severol weeks.
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Bronchitis ond Pneumonio		
Mild or Moderote Infections	250 mg q.i.d.	50 mg/kg/doy q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/doy q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Urinory Troct	500 mg q.i.d.	100 mg/kg/doy

*Dosoge should not result in a dose higher than that for adults.
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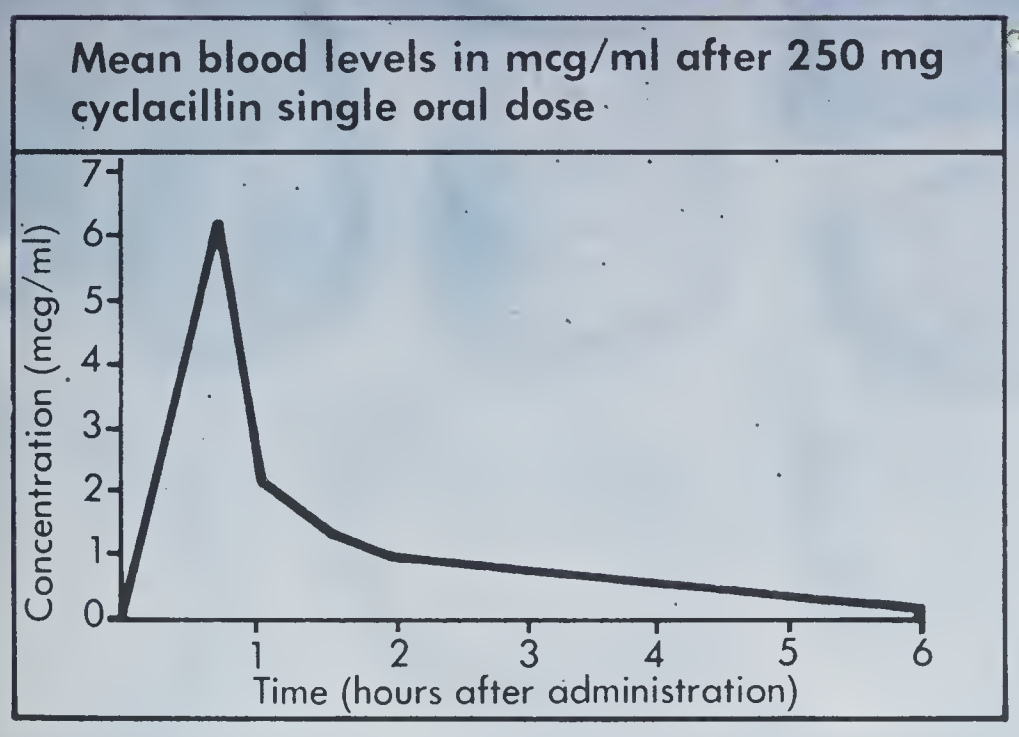

- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T^{a} ½ values far single aral dases of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data an file, Wyeth Labaratories.

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†Due to susceptible organisms.

See important information on facing page.

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Cardiac Rehabilitation

Jack Hataway, M.D.*
Glenda Barnes, R.N.*
Albert Oberman, M.D.*

Within the last five years cardiac rehabilitation programs have become increasingly popular. The basic principles of the program are simple; however, many pitfalls can interfere with designing and adequately maintaining such a program.

Cardiac rehabilitation programs can be divided into four phases. The first or acute phase is begun at the time of hospital admission and extends to three weeks post-myocardial infarction. In the next five weeks, Phase II occurs which is a progressive conditioning program. The objectives of Phases I and II are to limits the effects of deconditioning due to bed rest, to provide some increased physical reserve, and to develop a sense of increased security with increased activity[1].

* Phase	Time of Enrollment	Activities
I—Hospitalization	0-3 Wks Post Event	Patient/Family Education, Activities to avoid Deconditioning
II—Immediate Post Hospitalization	3-8 Wks Post Event	Supervised Walking/ Calisthenics
III—Intermediate	8-12 Wks Post Event	CV Monitored and Supervised Exercise Program, Risk Factor Intervention
IV—Long Term	12+ Wks Post Event	Endurance Activities

*All Phases are supervised, include patient and family education and are available at the University of Alabama in Birmingham Medical Center.

The recently completed program of the National Exercise and Heart Disease Project (NEHDP) dealt exclusively with Phase III and Phase IV conditioning for cardiac patients over a three-year period of time[2]. This five year collaborative study involved five medical centers throughout the country. Results indicated a decrease in mortality but no changes in morbidity among patients participating in the long term exercise portion of the program compared to the control group. This investigation of male survivors of myocardial infarctions supports the value of supervised exercise in reducing mortality and corroborates other non U.S. controlled trials[3-4]. Long-term benefits of exercise in a rehabilitation program include improvement of functional capacity, reduction of ischemic manifestations for the patient during ordinary activities, an improvement in the psychological outlook of patients, modification of cardiovascular risk factors, improved health habits and reduction of morbidity and mortality through physical training[5].

*Department of Preventive Medicine, The University of Alabama in Birmingham Medical Center.

The basic principles of cardiac rehabilitation include evaluation of the patient with a history and physical examination, an exercise test, and monitored, supervised and nonsupervised exercise sessions. The elements of the history and physical are directed specifically to determine any disease entities that might hinder a patient entering an exercise program. These include orthopnea, unstable angina, decompensated congestive heart failure, or the presence of other severe illnesses that would be adversely affected by exercise, and uncontrolled hypertension. Within our own cardiac rehabilitation program, even patients with three vessel disease have tolerated exercise programs safely.

Following the history and physical exam, the exercise test is administered and the patient taken to 90% of age and sex predicted maximum heart rate unless symptoms—sign limited prior to that time. Adverse signs and symptoms noted on treadmill testing such as ventricular tachycardia, increasing AV block, increasing number of PVCs or precipitation of angina, serve as limiting endpoints in themselves. For those exercising to 90% of age-predicted heart rate, the target exercise rate would be 85% of heart rate achieved plus or minus 5 beats per minute. For those exercising to self-imposed limits, e.g., leg discomfort, the exercise rate would be 85% of heart rate achieved minus 10 beats per minute.

The most commonly used tool for evaluation of persons entering this type of rehabilitation program is the multistage exercise test (MSET). There are numerous protocals used (Bruce, modified Bruce, Sheffield-Reeves, Balke, Ellestad), and they all have their strengths and weaknesses. The MSET is used to evaluate cardiovascular response to exercise (ECG abnormalities, psychological response), functional capacity, and physical appearance of the patient with exercise[6-7]. All of these elements are used to determine an adequate but safe exercise heart rate for the patient.

UAB Department of Preventive Medicine Program

In Phase III of our exercise program, the participants initially are introduced to a series of dynamic rotating arm and leg exercises which provide exercise to all muscle groups. Later in the program, emphasis is placed on training the large muscle groups of the legs. This initial monitored period of training has been shown to enhance feelings of self-confidence for the individual and provide a sense of security so that the patient can safely exercise at these heart rate ranges. Initially, body

composition, weight and physiological parameters change minimally. A conditioning effect, however, is noted with an actual exercise time of only 24 to 30 minutes a day three times a week at the recommended intensity. At the end of the six week period of supervised and monitored training at the Department, data from the treadmill test usually show a significant change in performance of the patient by increments of as much as 20 to 30 per cent.

After the initial training period, the Department participants enter Phase IV and undergo hourly supervised sessions at the UAB gymnasium three times a week. All patients are informed of the hazards of exercising in an unsupervised manner, but for those who elect to exercise on their own rather than use the gymnasium, the Department provides them with educational and informational materials. In the supervised programs at the UAB gym, twice a week, the participants enter into a walk-jog program for 30 of their 60 minute exercise time.

Warm-up stretch exercise and swimming account for the third-one hour session per week. Other types of activities include: medicine ball, calisthenics, skip rope, voleyball practice, or active volleyball games. Assessment of recent health problems and measurement of blood pressure and heart rate are taken before and after each session. Patients are instructed to monitor their individual heart rates during and after the walk-jog session and at end of the specified activity or sport. Body weight is recorded weekly. Any difficulties noted or encountered by the patients during the exercise session are immediately referred to the attending physician for disposition depending on the severity of the problem.

The cardiac rehabilitation program has been very successful at the Department of Preventive Medicine and has been a long-standing comprehensive program. Whether or not exercise prolongs life is clearly not known. Psychological benefits[8], cardiac risk factor attenuation, and physiological benefits suggest exercise is valuable in the treatment of post-myocardial infarction patients[9].

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Survey of Tetanus Immunity

by
Robert E. Pieroni, M.D.*
Terry W. Coplin, M.T. (ASCP)†
and
James D. Leeper, Ph.D.**

Abstract

Sera collected from 124 subjects from three counties in Alabama were assayed for protective antibodies against tetanus using toxin neutralization titrations in mice. The subjects' ages ranged from 13 to 86 years. Twenty-nine percent of those evaluated were found to lack protective antitoxin levels. Overall, susceptibility to tetanus was greater in older subjects, but no significant differences in immune status were noted among different sexes or races. Continued efforts toward complete prophylaxis of all age groups against this lethal disease are required.

Although the incidence of tetanus in Alabama and other states has decreased considerably, the case-fatality ratio of this disease has not changed substantially during this century.[1] In the past decade there were 23 deaths from tetanus in Alabama, according to the Bureau of Vital Statistics. Alexander, et al,[2] recently described the clinical course of three unimmunized Alabamians who contracted tetanus. One subject developed tetanus after a "clean, minor wound;" two of the patients died from complications of the disease. Recently, a state law was enacted which requires school children to be fully vaccinated. Although this is laudable, there still remain numerous Alabama residents who are susceptible to tetanus. Nearly 20 years ago, Levine and Wyman[3] conducted a large scale survey to determine immunity to tetanus among military recruits. Nationwide, 35 percent of the subjects were found to lack immunity to tetanus. In this survey, Alabama ranked lowest in the nation for tetanus immunity with fully 65 percent of those evaluated at risk for the disease.[3]

In a recent pilot study[4] of tetanus immunity in 35 patients at the Capstone Medical Center in Tuscaloosa, we found that about one-fourth of the patients were at risk for developing tetanus. The majority of the unprotected subjects were in the older age groups.[4] The study was subsequently expanded to include adolescent and adult subjects from other areas as well as additional subjects from the Tuscaloosa area.

This report analyzes the immune status to tetanus of 124 residents from various locations in Alabama.

Methods

The sample studied for tetanus immunity was from three sites in Tuscaloosa, Tallapoosa, and Cleburne Counties. Subjects from Tuscaloosa County were patients of the Capstone Medical Center, whereas those from Tallapoosa and Cleburne Counties were evaluated during comprehensive health screenings at New Site and Ranburne conducted by the University of Alabama Student Coalition for Community Health.

Aliquots of sera from patients undergoing routine lab testing in these areas were analyzed for tetanus antibodies by neutralization titration in mice.[5] Testing was performed initially at the Masachusetts Department of Public Health Biologic Laboratories and later at the University of Alabama using standardized methods.[5] Results are expressed in anti-toxin units per ml of sera in comparison to the standard anti-toxin provided by the Bureau of Biologics of the Food and Drug Administration. Patients with antibody levels less than 0.01 anti-toxin units (AU/ml) were considered at risk for developing tetanus as previously described.[6,7]

Analysis for possible differences in total immunity among the three counties was evaluated using a Chi-square test. Sex and race effects were analyzed using the Mantel-Haenszel method for combining data from fourfold tables.[8] This mehtod allows a test for differences among counties and also a test for an association between sex and immune status as well as race and immune status. Age was analyzed using a 2-way analysis of variance with immune status as one factor

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and county as the other. The gradient in proportions across age categories was tested with a Chi-square statistic.[9]

Results

The majority of the 124 subjects surveyed was from Tuscaloosa County (85). Fifteen were from Tallapoosa County and 24 from Cleburne County. Table 1 summarizes some of the characteristics of the sample under study. The majority were female (70%) and white (73%). Ages ranged from 13 to 86 years; young adults represented a high percentage of subjects studied. Overall, 88 of the subjects (71%) had protective antibodies against tetanus. In Tuscaloosa and Tallapoosa Counties 73% were protected compared to 63% in Cleburne County. No significant differences were noted among the samples of the three counties in degree of protection against tetanus ($X^2=1.04$, $p=.59$). Also, no significant differences in immune status were detected between different sexes and races ($X^2=2.48$, $p=.12$ and $X^2=0.16$, $p=.69$ respectively). The mean age of immune subjects was younger than the mean age of subjects at risk for tetanus in all areas surveyed, but this age effect was most notable and statistically significant only in Tuscaloosa County (37.5 years vs. 63.9 years, $t=6.44$, $p > .0001$) where larger numbers of subjects were studied. The overall effect of age on immune status is depicted in Figure 1, which shows a definite trend toward decreasing immunity with advancing age ($X^2=22.09$, $p > .0001$).

Table 1. Demographic Features of Patients Surveyed for Tetanus Immunity

	Protective Antibody*				
	Neg.	Pos.	% Protected	X^2	p
Sex					
Male	7	30	81	2.48	.12
Female	29	58	67		
Race					
White	26	65	71	0.16	.69
Black	10	23	70		
County					
Tuscaloosa	23	62	73	1.04	.59
Tallapoosa	4	11	73		
Cleburne	9	15	63		
Total	36	88	71		

*Protection defined as serum antitoxin titer ≥ 0.01 AU/ml.

Discussion

The purpose of this study was to evaluate immunity to tetanus in several different geographical regions of the state in order to obtain a very rough overview of tetanus immune status. An *in vivo* test, the mouse neutralization assay, was selected for this survey becuase of its precision and accuracy in estimating antibody.[10] This test, however, is expensive and time-consuming and, therefore, allows only a limited number of subjects to be studied from different areas. The samples were not selected randomly from the populations and, therefore, cannot be considered representative of the total populations. However, some findings are of interest.

Overall, 29% of 124 subjects were found to be unprotected against tetanus. This value is close to our previous results using a different patient population in Tuscaloosa County where 26% of the subjects were found to be at risk for tetanus.[4] As in our earlier study,[4] there were no statistical differences in immune status detected among different sexes and races. As before, the ages of the subjects susceptible to tetanus, however, was greater than for those subjects with protective antibody levels (Figure 1). This effect was most marked in Tuscaloosa County where most of the subjects were urban residents. The relatively greater protection among the elderly in Tallapoosa and Cleburne Counties could possibly be a result of more frequent use of tetanus toxoid boosters among these largely rural inhabitants with more exposure to tetanus-prone injuries. This possibility deserves further study. Both statewide and nationally a large proportion of tetanus cases are found among elderly subjects,[11] a population whose immune status has been shown to be inadequate in several surveys.[4,10]

As has been emphasized by Alexander, et al,[2] "tetanus cannot be prevented in previously unimmunized persons by administration of tetanus toxoid at the time of injury." Many subjects who contract tetanus give a history of having sustained only a "minor" wound, or, in fact, no wound whatsoever.[2] Proper tetanus immunization with periodic boosters, however, will confer virtually complete protection against this dread disease in vaccinees.

Although the incidence of tetanus has shown a steady decline, the high but avoidable morbidity and mortality from this disease persists. The recent state law requiring full vaccination of school children should help further reduce the incidence of tetanus. Unfortunately, as the present immunity survey suggests, there are many thousands of Alabamians who remain unprotected against tetanus. Surveys of other states have revealed an even higher proportion of unprotected subjects.[1]

Tetanus toxoid is safe, inexpensive and nearly completely effective in inducing antibody response. The recommended schedule for active immunization of normal infants and children consists of administration of diphtheria and tetanus toxoids combined with pertussis vaccine (DPT) at 2 months, 4 months, 6 months, and again at 1½ and 4 to 6 years of age. Combined tetanus and diphtheria toxoids (adult Td) are recommended for

those greater than six years of age, with booster immunizations at ten year intervals to sustain immunization. Primary immunization for adults who have never received toxoid consists of three intramuscular injections of Td, with 4 to 6 weeks separating the first and second doses and 6 to 12 months between the second and third doses.[11,12]

Tetanus has been termed the "inexcusable disease."[13] Since maintenance of defenses against tetanus is relatively simple and safe in comparison with the consequences of acquiring the disease, universal prophylaxis against this disorder should remain an important goal of all health care workers.

Acknowledgments

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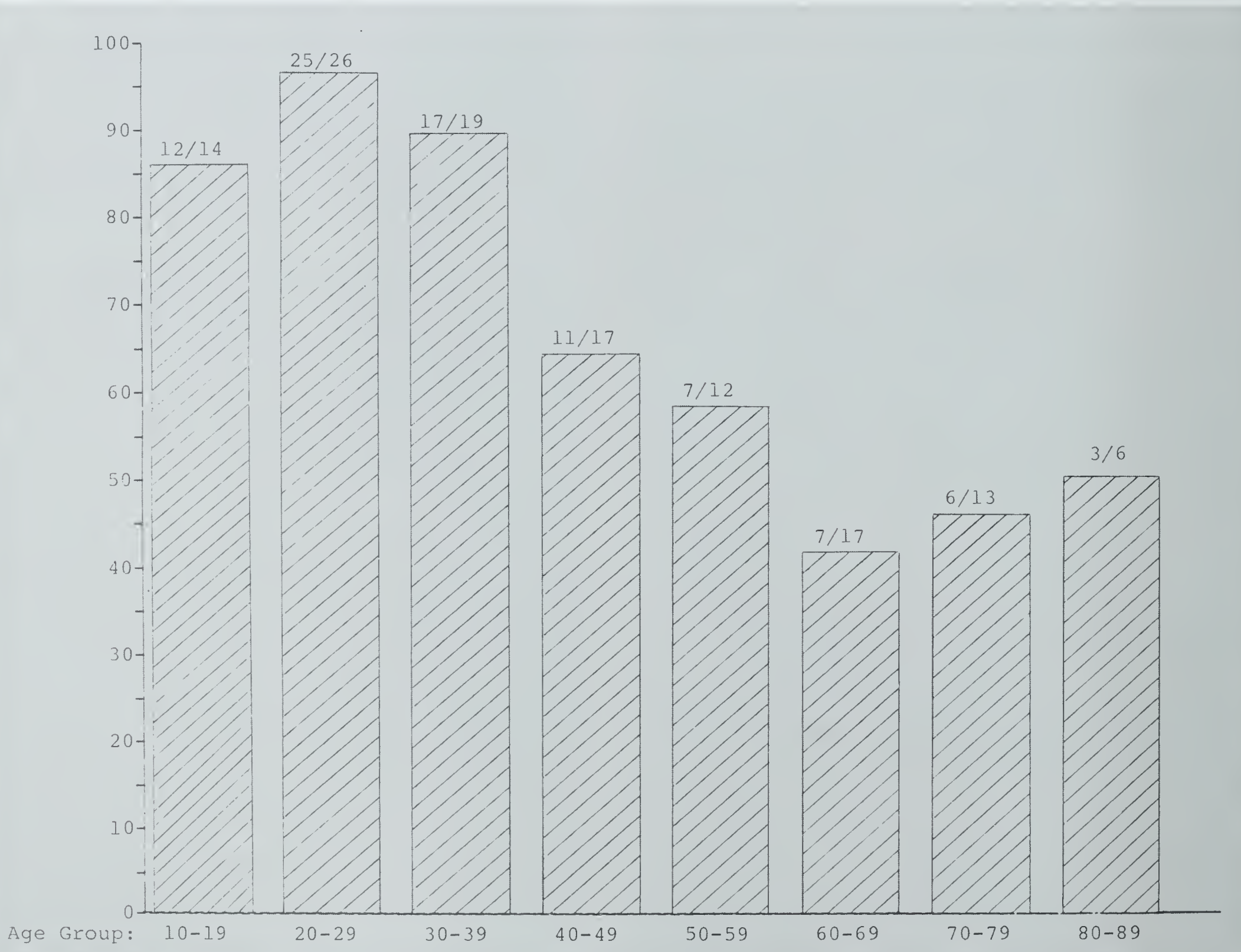
Figure 1. Percent Immunity to Tetanus Among Different Age Groups



Percent immunity to tetanus among different age groups in the three counties surveyed. Percent immunity defined as percentage of subjects in each age group with serum antitoxin levels ⩾ 0.01 AU/ml.

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Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

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ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

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Dr. Talbott talked to us about the stigma surrounding the problem that prohibits physicians from seeking treatment. Alcoholism is a treatable disease—not a moral issue as we have always been taught. The doctor who is chemically dependent cannot reach out for help and there are many reasons for this. Some of the main characteristics are the same as the ones that enabled him to become a doctor in the first place. He has a large ego, a great deal of pride and he thinks he can handle the problem alone. He also has some guilt, shame, embarrassment, and a very strong fear of losing his practice. The spouses and children suffer the same symptoms and so they join in a conspiracy of silence. Therefore, if they are to receive help, it is up to you and me to see that they are put in contact with someone who has trained to intervene, counsel, and guide them to treatment centers.

We have always heard that the alcoholic cannot be helped until he reaches "skid row" and begs for help. This is a myth. The highly successful Disabled Doctor's program in Georgia has been responsible for the treatment of at least 200 doctors who have returned to practice. Based on national statistics, Alabama is expected to have a minimum of 450 Impaired physicians. There are now 48 states with Impaired Physician programs.

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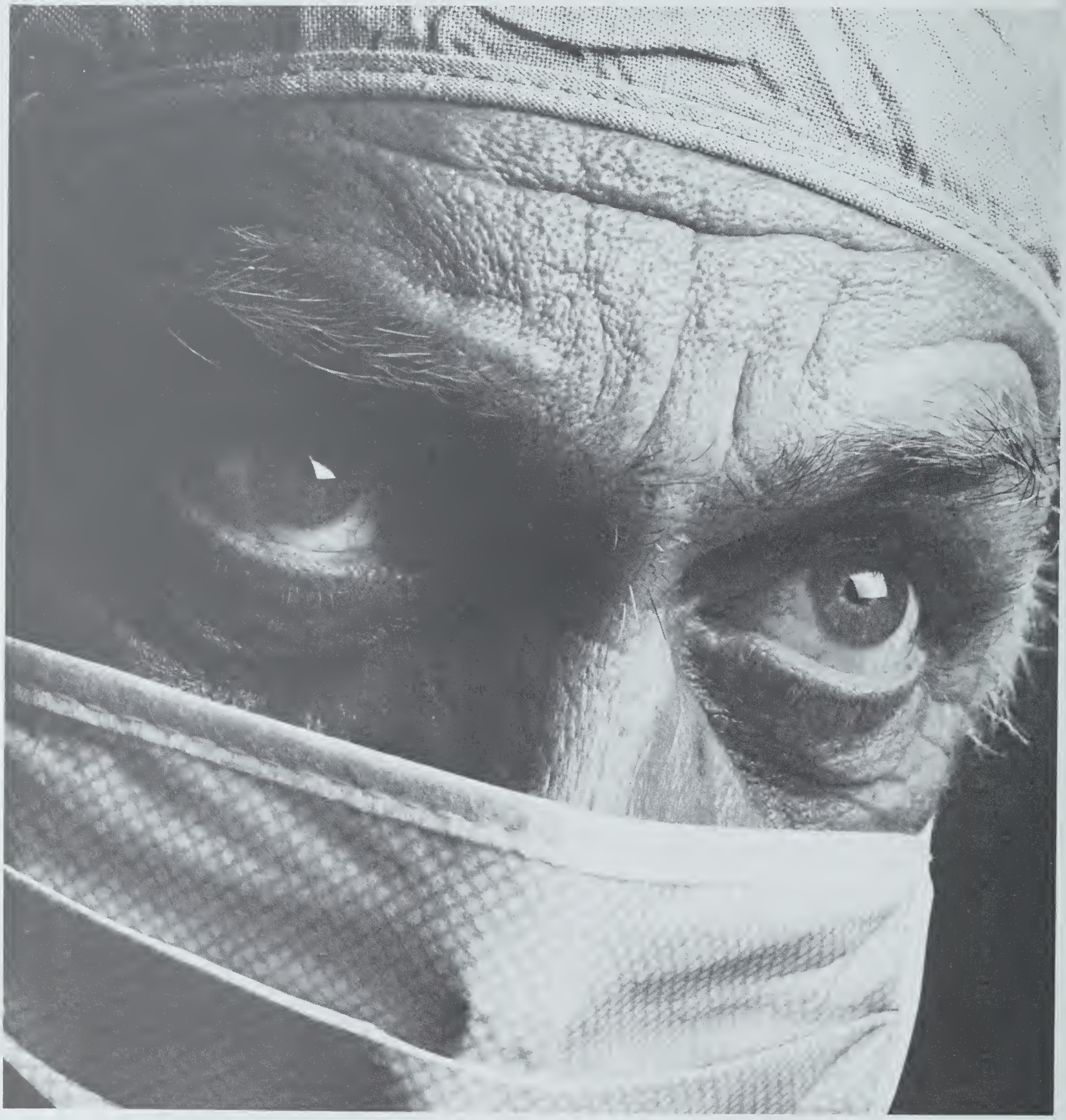
Mary Julia Lee



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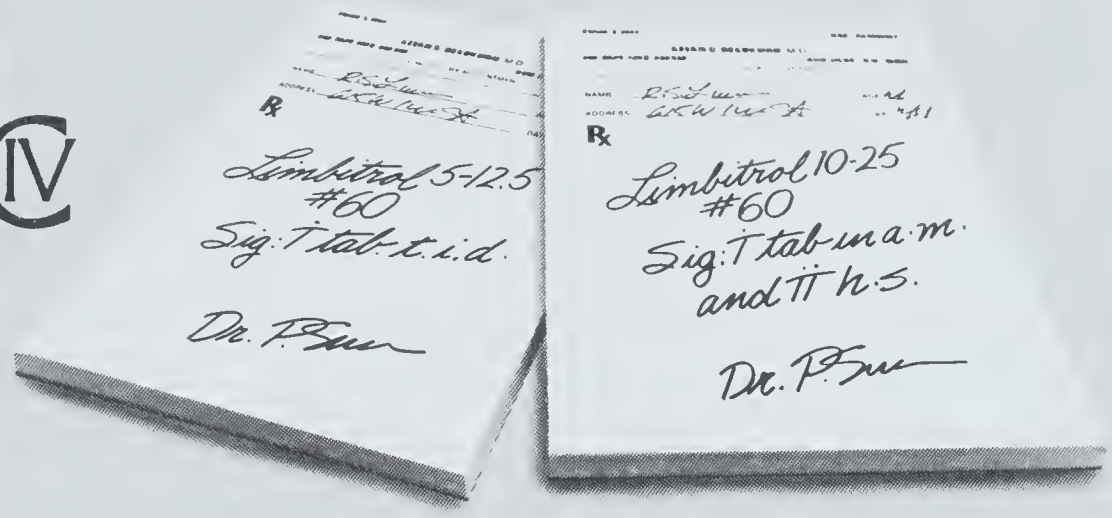

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Most patients with a mood disorder have a mixture of anxiety and depression. One clinician[1] found a correlation of 0.7 in anxiety and depression scores; another[2] has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

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Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression that contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.[2,3]

Avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and other extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970. **2.** Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **3.** Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress,* edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p. 999.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

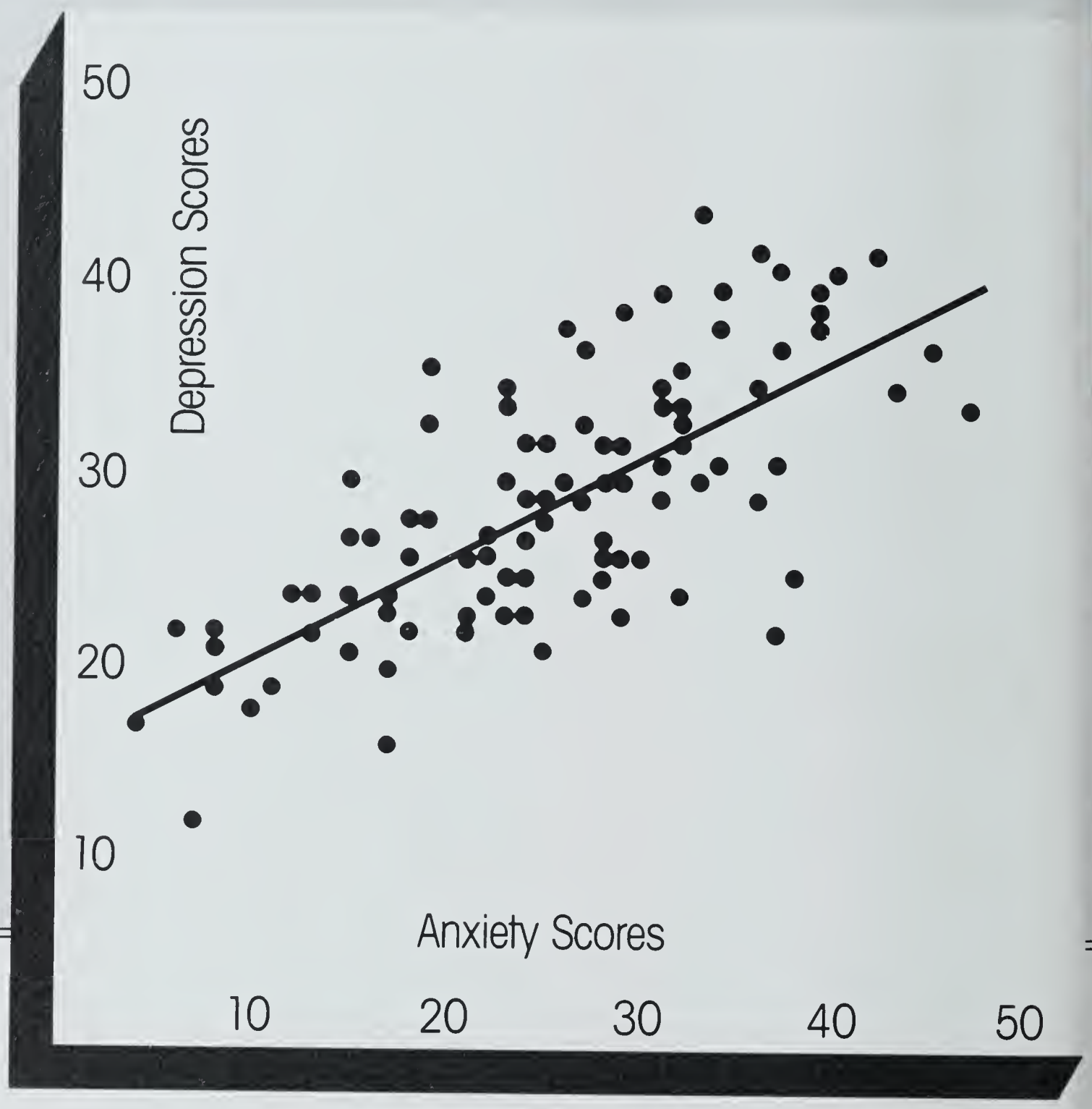
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

ROCHE®
ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

MORE DEPRESSION MEANS MORE ANXIETY...



The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.

—Adapted from Claghorn J[1]

A key reason why

MORE PHYSICIANS ARE CHOOSING LIMBITROL®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

ROCHE®

1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970

Please see summary of product information on inside cover.

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Dean Crawford: Boom Town USA

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Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/ Roche)®, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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The Vanishing Indian

I hope you read with care our account in **The Alabama M. D.** July 30, of the General Accounting Office's failing report card on Health Systems Agencies.

The report came to the general conclusion that HSAs have not been effective in containing the costs of medical care to any measurable degree (and may, in some instances, have actually been counter-productive). But a criticism threading through the GAO's report is one on planning itself.

GAO seemed to be saying that most of the planning had as its objective **more planning**—not health care for the American people. Small wonder that physicians who have attempted to become involved in the planning game quickly become frustrated and angry. The Bureaucratic Game is planning: My plan can lick your plan. While there may be some fun in The Game, since any number can play, it has little to do with health care, the physician's primary interest.

In point of fact, this is precisely what is meant in the criticisms of what American government and industry have become in times of relative peace and prosperity—top-heavy with **planners** rather than **doers.**

Generations of bright young Americans have been educated in the belief that everyone can be a Chief, since the country has somehow found the magic formula to make do without Indians.

Up until about 20 years ago, the major business schools of the nation were built on a three-legged stool—Finance, Marketing and Production. But over the years interest in the third leg, Production, lagged. Production was too close to blue collar for the liking of most aspiring young executives, who wanted to be in the high-rise steel and glass office buildings, planning and pushing buttons.

Soon, according to a recent **Wall Street Journal** series on the subject, the business schools simply stopped teaching Production, involving as it did that vital link between management and the assembly line, the edge between concept and reality, design and function. It was too sweaty for the liking of the young princes of industry.

And what happened? The Germans and Japanese, whose executives are usually expert doers and engineers, began to lick us at our own game, in both productivity and quality control. Suddenly, the nation began to panic. As one major industrialist told **The Wall Street Journal** in a moment of dismayed self-discovery:

"We can finance it brilliantly. We can market it better than anyone. We just can't make it."

All of a sudden, thoughtful men and women in business, government and industry began to look around at what had been wrought. They discovered themselves knee-deep in planners, designers, consultants and other assorted chiefs, but pitifully thin in the Indians who could make it, produce it, turn it out.

It is easy enough to blame it all on organized labor, whose straw bosses have taken over many of the production supervision jobs in many cases. But they only moved in because management abdicated the production responsibility.

Professor C. Northcote Parkinson, the brilliant observer of the bureaucratic phenomenon, noted something similar in Great Britain between the two great wars. As the number of capital ships of the line—battleships and the like—went down, the number of admirals and other deskbound chiefs went up in the British admiralty. As there was less work to do and fewer people to do it, the number of planners increased, at times almost geometrically.

This has happened throughout our society, it appears. A certain amount of planning is, of course, necessary to any enterprise, but planning has become an end in itself. Industry has discovered, for example, that nobody wants to be what used to be the most skilled of the machinist specialities—the tool & die makers, those artists who design and make the gears, the widgets and the millions of vital parts that keep the engines of America running.

Why was no one coming up to take the place of these old craftsmen? Because their sons saw the salaries were much better and the work a lot more pleasant in the high-rise executive suites. So they went off to college to learn planning, thus to be chiefs rather than Indians. The pay of tool & diemakers began to languish and the sons of the great masters were soon easily earning multiples of their father's salaries pushing buttons and drafting plans. And their education period was much shorter than their fathers' long apprenticeships.

Doctors are like these tool and diemakers in a way. They are the doers, the Indians if you will, that everyone wants to boss. The tree full of owls that the HSAs have become is a classic example of planning run amok, and of Prof. Parkinson's example of the British Admiralty—top-heavy with people whose only function is to grind out more and more plans for the few doers left on the bottom of the pyramid.

All of us are familiar with the old saying: Those who can, do. Those who cannot, teach. A third element has been added in the society of theoreticians anticipated by Prof. Parkinson:

Those who can neither do nor teach, plan.

Jon

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Stress In The Medical Family

For the child in need . . .

Hill Crest Hospital has

extensive facilities for the treatment of children and adolescents with a wide range of emotional and behavioral disorders.

Its child/adolescent program consists of three separate components:

- **Child/Adolescent Unit**—a self-contained inpatient treatment area providing a structured therapeutic environment. It provides short and intermediate term care within the hospital setting.
- **Higdon Hill School**—located on the hospital campus, this is the educational division of the hospital. It provides special educational evaluation and individually tailored academic programs by specially trained teachers certified by the State of Alabama. It provides services to children aged from 6 to 17, whether in the hospital or from the community.
- **Higdon Hill Home**—a long-term residential treatment facility also located on the hospital campus. It provides services for youngsters between the ages of 12 and 17 who are experiencing emotional and behavioral problems.

FOR MORE INFORMATION CALL:

Child/Adolescent Unit: 833-9000, ext. 231 · Higdon Hill School: 836-1742 or 833-9000, ext. 291
Public Relations: 833-9000, ext. 219

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Pioneers in Medicine
For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine. Some of our better known products are Lopurin™ , Ru-Tuss® and Ru-Vert® . This advertisement highlights four other products particularly useful for the family.

F-E-P CREME® • SU-TON® • TWIN-K® • TWIN-K-CI™

For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin – Pramoxine HCl – Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (½ ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications.
See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.

For Potassium Supplementation Improved Compliance...

TWIN-K®

ach 15 ml supplies 20 mEq of potassium ions as a combination of potassium luconate and potassium citrate in a sorbitol and saccharin solution.

The good tasting potassium supplement

- Designed for prophylactic and therapeutic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient dosage aid patient compliance.

The organic salt of potassium can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine.[1]

. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, page 1959.

In Cases with Chloride Deficiency...

TWIN-K-CI™

Each 15 ml supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride in a sorbitol and saccharin solution.

The good tasting potassium supplement with chloride

- In hypokalemic hypochloremic alkalosis, chloride ions are required. Twin-K-Cl is specially formulated to be a good tasting chloride containing potassium supplement.
- Contains no potassium chloride. Twin-K-Cl is a carefully balanced combination of organic potassium salts plus ammonium chloride.
- In hypochloremic patients, potassium should be provided as the chloride salt, or chloride ion must be made available in some other form, such as ammonium chloride or sodium chloride.[1]

See prescribing information on last page of this advertisement.

F-E-P CREME

DESCRIPTION
F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma, nuchal eczema and chronic eczematoid otitis externa, acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris corporis, pedis); moniliasis; intertrigo. Final classification of the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS
Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS
This product is not for ophthalmic use.
In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY
Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboratory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS
F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period.
Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests. The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine.
Prolonged use of this drug may result in an overgrowth of non-susceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS
Skin rash or hypersensitivity may occur following topical application.
The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION
Apply a thin layer of the drug to affected parts 3-4 times daily.
Note:
1. F-E-P Creme is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. F-E-P Creme (Plain) is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED

F-E-P Creme	½ ounce (15 gm) tubes	NDC 0524-0026-51
F-E-P Creme Plain	½ ounce (15 gm) tubes	NDC 0524-0025-51

Federal law prohibits dispensing without a prescription.
July 1980

SU-TON®

DESCRIPTION
Forty-five milliliters of SU-TON contain the following ingredients:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

INDICATIONS AND USAGE
SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

CONTRAINDICATIONS
Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS
The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS
Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

ADVERSE REACTIONS
Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE
Drug dependence has not been reported with SU-TON.

OVERDOSAGE
Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.
Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION
One tablespoonful (15 ml) 3 times a day 20-30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED
Bottles of 473 ml (16 fl oz) NDC 0524-0015-16
Federal law prohibits dispensing without prescription.
February 1980

TWIN-K®

DESCRIPTION
Each 15 milliliter (one tablespoonful) supplies 20 mEq of potassium ions as a combination of potassium gluconate and potassium citrate in a sorbitol and saccharin solution.

INDICATIONS AND USAGE
For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS
Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS
TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.
To minimize gastrointestinal irritation, it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS
Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.
The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.
Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.
In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS
Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.
TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE
The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes. Treatment measures include:
1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION
The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mEq of potassium ions. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K are to be avoided.
Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED
Bottles of 1 pint (16 fl oz) NDC 0524-0021-16

CAUTION
Federal law prohibits dispensing without prescription.
July 1980

TWIN-K-CI™

DESCRIPTION
Each 15 ml (one tablespoonful) supplies 15 mEq of potassium ions and 4 mEq of chloride ions as a combination of potassium gluconate, potassium citrate, and ammonium chloride, in a sorbital and saccharin solution.

INDICATIONS
For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Potassium and chloride are usually the salts of choice in the treatment of hypokalemia since chloride and potassium deficiencies are likely to be associated with each other.

CONTRAINDICATIONS
Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS
TWIN-K-CI is a palatable form of oral potassium replacement. Excessive, undiluted doses of TWIN-K-CI may cause a saline laxative effect.
To minimize gastrointestinal irritation, it is recommended that TWIN-K-CI be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS
Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8-5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.
The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.
Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function, it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since, usually, the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic EKG and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.
In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K-CI is recommended for use in these patients.

ADVERSE REACTIONS
Symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiograpic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.
TWIN-K-CI taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE
The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired, potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with or without EKG changes:
Treatment measures include:
1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10-20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia, it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION
The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 30 to 60 mEq of potassium ions and 8 to 16 mEq of chloride ions. The usual preventative dose of potassium is 20 mEq per day while therapeutic doses range from 30 mEq to 100 mEq per day. Because of the potential for gastrointestinal irritation, undiluted large single doses (30 ml or more) of TWIN-K-CI are to be avoided.
Deviations from this schedule may be indicated, since no average total daily dose can be defined, but must be governed by close observation for clinical effects.

HOW SUPPLIED Bottles of 1 pint (16 fl oz)
NDC 0524-0022-16

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PRESIDENT'S PAGE

J. Kendall Black, Jr., M. D.
President

Where Are We Going Together?

In a recent speech before the Federation of State Medical Boards, Dr. Robert B. Hunter (then president of the American Medical Association) asked just that question. Each of the many organizations of physicians has its own positions on singular issues. They know where they are coming from, just as we know where the AMA and MASA are coming from. But a major burning question today for organized medicine is—where are we going collectively?

Given the natural independence of our profession as well as the plethora of medical knowledge and scientific technology that exist in the world today, it is only natural that physicians of various specialties and subspecialties would band together into groups for the exchange of information. The principles of independence of personal, social and professional freedom are at the bedrock of our democracy. This organizational structure has been extremely beneficial for our society in terms of medical research education and practice.

However this same independence and organizational structure can also be divisive. And there has been and is considerable divisiveness within medicine. Individually and collectively, each of us tend to approach problems with somewhat parochial solutions. Too often, we overlook the collective needs of our profession. This frequently results in a wide divergence of views and positions as well as a dichotomy of action.

While there is still plenty of room as well as need for independence in medicine, there is no room at all for irresponsible independence. That kind works against us rather than for us. There is a point at which our individual interests must give way to our professional interests. And there is a point at which our professional interests must give way to the public's interests. We must recognize that there is a point where independence ends and interdependence begins.

In terms of numbers, physicians represent two-tenths of one per cent of the population. That our influence far exceeds our numbers is living testimony to our individual integrity, the quality of our care, our common collective goals, and the unity of our organization. The continuing fragmentation within the profession can only serve to dilute our influence and damage our credibility.

The AMA, through its federation of state medical societies, and MASA, through its group of county societies, are the organizations that can be and should be on the cutting edge of our responses to the crucial socio-economic, political and professional issues that now exist or are pending. These are the organizations that represent medicines collective community.

There are profound changes ahead. In large part due fragmentation, the profession has slipped into a defensive posture on many of the issues. This is not as it should be. We must be the thinkers, the innovation, the leaders. We owe it to ourselves and our profession. But most of all we owe it to our patients.

/Kendall

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You Win With Decisions

By
Claude L. Brown, M.D.

Wherein Dr. Brown, Mobile psychiatrist and veteran sailor, appears to lapse into fantasy. His meanings will be clear to other sailors, inscrutable to landlubbers.

After years of spectacularly unsuccessful racing, in vessels from dinghies to dahabiyahs, I have come to a chastening conclusion. Long did I labor, marvelous and profound were my arguments, but accumlated evidence weighed too heavily and the shining truth struck me: losing is mostly my fault. A corollary of this remarkable proposition is that success in yacht racing comes mainly from making proper decisions.

For instance: you don't win many races if you're picking daisies. Yet on some boats there is too much preoccupation with irrelevant issues.

My friend, Ogden, is an extreme example of this unhappy trait. A good seaman, he vaguely hopes to win but like many skippers he is partially daft. When he steps on board his wind goes adrift, a fantasy grips him securely: he is Nelson at Aboukir Bay, Drake facing the Armada in the Channel, or Captain Cook off the Great Barrier Reef. He has a repertoire of naval personages into which he becomes reincarnated; from his mutterings I can sometimes get a fix on him.

On this day he had mumbled something about "a man in the chains to get us across these shallows" so I figured him for Nelson. Four of us were crewing with him on his sloop, Agamemnon. ("Old Aggie", we called her, to his profane dismay.) We were hard on the wind, port tack, in a stiff breeze, and converging with a starboard tacker who was four hundred yards distant.

I announced, "Ogden, we're converging with the 2-30 and it's going to be close."

Skipper Ogden-Horatio lay on his back on the cabin top. His gaze seemed fixed on the masthead but, transposed in time and space he beheld the coast of Egypt, hazy in sunset. He said nothing.

Seconds passed, the other boat hailed.

"Ogden," I asked urgently, "Shall we slack a little and run under him?"

Horatio snapped, "Alter course and I'll have you flogged through the fleet at Spithead!" He still stared at the masthead.

We were 60 yards apart now. The other helmsman peered anxiously beneath his boom at us. At our tiller Ed eased to a half-crouch.

I shook Ogden's shoulder and cried, "We're going to hit him at his port chain plates in about 10 seconds."

He said moodily, "Excellent. I trust you have the guns loaded with solid shot, Mr. Brown."

Inspiration saved me. "Your Lordship, wouldn't it be well if we crossed his stern and crippled his rudder with our fire?"

Ogden was up instantly, "Helmsman, bear off!"

Our bow sliced by the other's transom, six feet away, with Nelson of the Nile shouting exuberantly, "Fire as your guns bear!"

At the club later a crewman from the other boat said, "You shouldn't sail like that. Ogden doesn't win races with that scare-'em stuff."

Ed replied, "But we sink a lot of Frenchmen."

Sail Ahead Of The Boat

Usually we are not as preoccupied as Ogden, but it is too easy to lapse into some reverie, or to be distracted by conversation, or (and this is probably the most besetting sin) to be complacent with the status quo. Constant attention and anticipation—"looking ahead"—is the order of the day.

Of course, it's always popular to point the finger at Luck. Long ago Virgil asked, "Why should I trust Aeneas to the mercy of the fallacious winds?" In weak and despairing moments I may blame luck, but even as I denounce the perversity and inscrutability of fate I hear that still, small voice say, "It was you, brother, that blew it." And that voice, darn-it, usually speaketh true. Stripped of my face-saving egoism, my sincere rationalizations, and the cup that I didn't win, I must, if I'm dimly perceptive and half honest (isn't that par?) confess that the defect is mine.

A study of my results of the recent season shows that in only one race was luck really a paramount factor. In this instance we handled the boat precisely, put her just where I wanted to be in retrospect would have done everything exactly the same and ended very much on the wrong side of a major wind shift. That, I think, really is tough luck.

In another race we lost a probable first overall by a singular misfortune that most observers called luck. We were leading the fleet at the end of a day of gossamer wind and baking heat when we ran over something that bumped heavily against the hull. Nothing appeared astern. I went forward and saw the end of a plank protruding perpendicular to the forefoot, just beneath the surface. With the boat hook I shoved the end downwards as hard as I could, and the plank vanished. *But we never saw it in the wake.* Our nearest opponent slowly overhauled and passed us, and the boats much farther astern gradually gained. Finally the realization crystallized in all of us that something was radically amiss. The wind freshened, the sea roughed a bit, and presto! the board announced its presence by again bumping the hull. We luffed up, a crewman jumped over the side and quickly back aboard with a six foot two-by-six. No rope, no nails, no cross-pieces—just water pressure had plastered it against the hull in a calm sea. We had carried it seven miles. An unusual tale—one that I might not believe were I not telling it.

But was this occurrence sheer luck? When looked at coldly I see the rationalization (that I had removed the board) adhered to from fatigue and boredom with the long, hot race. It's like navigation, make that initial mistake and everything that follows is wrong. Really, I had misgivings when we saw nothing in our wake. And when the other boat passed us these misgivings were intensified. But this knowledge was suppressed by our general lessening of acuteness, and was only driven into awareness and consequent purposeful action when we had slowed so drastically that we could no longer ignore the facts. Our failure was not due to pure chance; it was not unforeseeable and uncorrectable misfortune but rather my improper decision.

The Shipper's Lot

A complex activity has many components, any one of which may be vital. You can't ordinarily expect to win with a non-competitive hull, inadequate sails, a poor crew, or any other of the usually assumed prerequisites. But is it not the skipper's responsibility to have these necessities? If my crew is incompetent, my sails no good, and the beer all gone — is it not I who must remedy these problems?

Sometimes we make a proper decision, and then fail to change it when conditions change. Failure to change may be produced by unawareness (from fatigue, distraction, inattentiveness) or by some stubborn resistance inside ourselves that defies alteration. On a recent night race we became surrounded by large thunderheads, filled with lightning and rumblings. We were carrying the kite, and were waiting, waiting. With the first cool breath that usually precedes the onslaught of the squall we struck the kite and hung out the genoa. Although the squalls stayed close around us for four hours, with great electrical display, no strong wind ever came. Yet we never hoisted the spinnaker during those hours. Nor did we do well.

The first decision — to douse the spinnaker — was proper; every indication was that a squall would hit us in seconds.

The second decision — not to re-set the kite — was improper. After waiting a short while we should have put it up. The plain fact is that the quite threatening weather affected us unduly. We inappropriately dwelt on potential damage to the spinnaker or pole; we worried about foredeck work at night in a rough sea; we dealt on gruesome details of dismasting. In short, we were fearful.

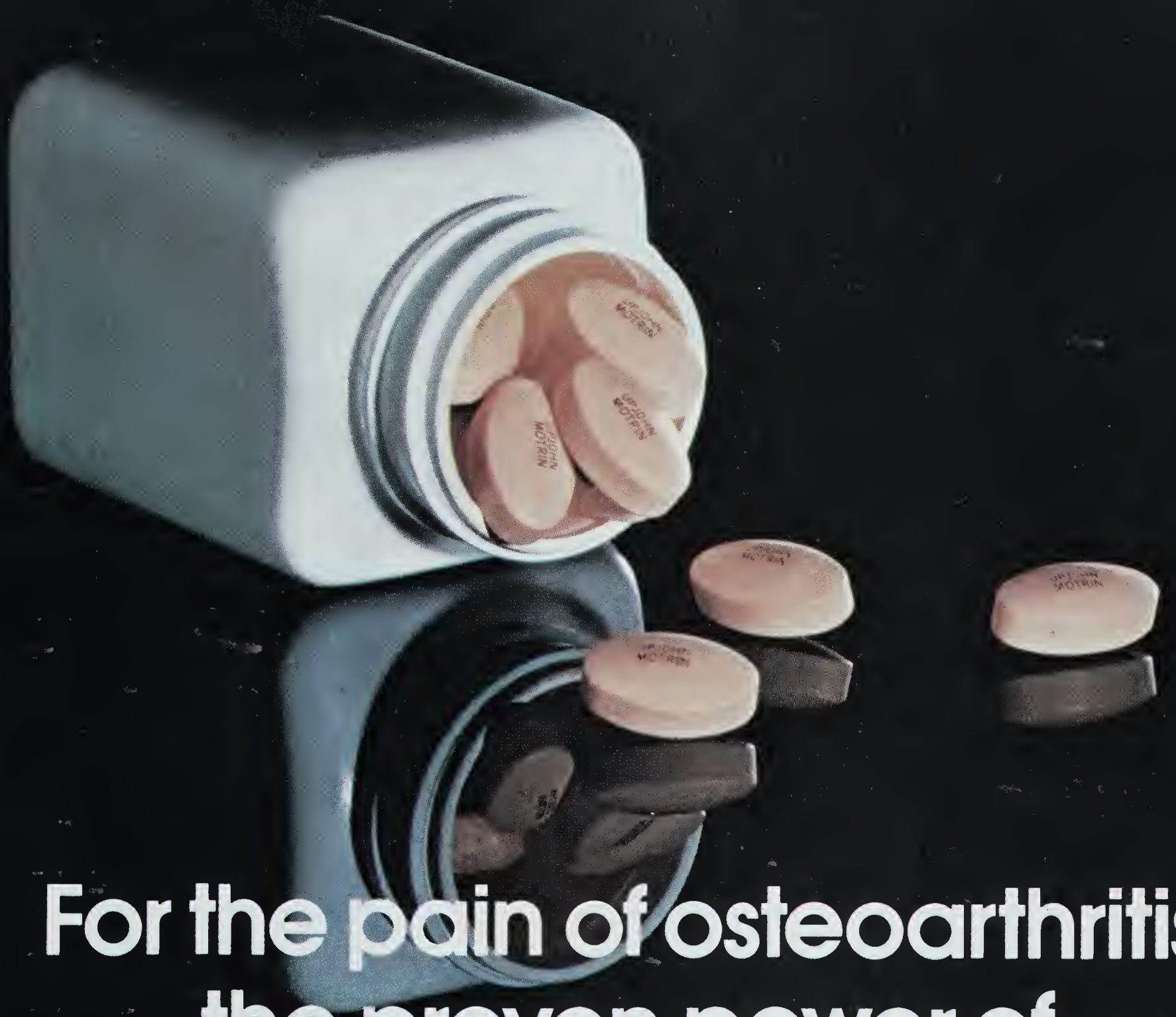
Fearfulness is a subject that isn't so often mentioned, and very rarely have I heard of it as a reason for not scoring. Yet fear is a potent factor, not to be discounted. We make all the usual excuses for our failures, but we hate to admit that perhaps we scared ourselves out of a cup. It just isn't manly to say, "I didn't try as hard as I could because I was too frightened." It's not in the stout-hearted, don't-shorten-sail tradition of the sea to whimper, "I'm cold, wet, tired, sick and scared."

Fear Is Irrational

Most fear is irrational. Of course, it is foolish not to take all reasonable precautions — but the catch is the word "reasonable." In the example given above our reasonable concern assumed unreasonable proportions. We were intimidated by our morbid fantasies, and thus became as ineffectual as did my friend, Horatio-Ogden with his more pleasant imaginative flights. In retrospect: if we had blown the kite, we had another; the chances of dismasting a sturdy boat are rather remote, but had this occurred we had bolt cutters, a good engine with ample gas to get us to shelter, etc. The foredeck would have been bouncing, but with safety harnesses our working up there surely would have been safer than driving to work every morning.

Excessive caution is just what it says: too much caution. Caution that is not only unnecessary, but often ruinous to race results. But there can be too little caution, a lack of prudence.

I crewed briefly (only briefly, for my nerves failed) with Bertrand the Bold. Bert erred on the side of having no caution at all. I never decided whether this serene blindness was due to bravado, incorrigible ignorance, or a sublime belief in his personal invulnerability. In his quaint modus operandi was an absolute rule: Carry the kite if the wind is aft of the beam. Thus, one dirty day, with the wind at 35 knots broad on the starboard quarter,



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Motrin®

ibuprofen, Upjohn

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One tablet t.i.d.

Please see the following page for a brief summary of prescribing information.

Upjohn

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Motrin® Tablets (ibuprofen, Upjohn)

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other non-steroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin;* use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.
Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)–Probable Causal Relationship

Gastrointestinal: Nausea;* epigastric pain;* heartburn;* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness;* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%–Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%–Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship" (PCR)* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Caution: Federal law prohibits dispensing without prescription.

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-5-S

J-9042-4

July 1981

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VOLUME
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America: Land of Wonders

Daniel T. Cloud, M.D.
President, American Medical Association

My more than 30 years of travel down the corridors of medicine were memorable, exciting years, full of adventure, challenge, and unforgettable experiences—years warmed by cherished friends.

I would like to reminisce a bit and take you back to the 40s. A thing that would affect our lives for years to come, called socialized medicine, enveloped Great Britain, soon gathered momentum in Washington, and loomed as a major obstacle to the private practice of medicine in America.

The AMA leadership made a bold, far-reaching decision. It was in 1948, shortly after Harry Truman was elected President in an upset over Tom Dewey. For the first time in AMA history, the leadership levied a $25 voluntary assessment. The membership rallied, and $2,250,000 was collected.

That was a dramatic turning point for the AMA. It was also the start of my strong affinity for this great organization. I admired that decision our leaders made then, even though I was but an intern, and in the light of what has transpired, I admire it even more today. Think of the incredible soul-searching they must have done.

In the 60s and 70s, the politics of medicine increased its tempo, and a succession of political aggressions came along to challenge our professionalism and our freedom.

Over the years, the great debate on how to deliver medical care took many turns. We faced proposals to ration care with tricky cost cap devices, and to limit utilization with complex and unworkable systems. The Federal Trade Commission accused us of antitrust, challenged our principles of ethics, our role in medical education, and other activities aimed at protecting the public interest.

GMENAC, the controversial Graduate Medical Education National Advisory Committee, founded by HEW more than four years ago, reported that careers in medicine should be curtailed to head off a physician glut they predicted for 1990.

We have health planning laws, PSRO, subsidized HMOs, privacy invasions and more. The pattern is familiar and the picture is clear. Forces in government have waged a great campaign to seize control of health care and relegate the private practice of medicine to a subordinate status.

But we have not succumbed. National Health Insurance: Defeated. Hospital Cost Cap: Defeated. Utilization Regulations: Defeated. Health Planning: In trouble. PSRO: In trouble. HMO Subsidies: In trouble. GMENAC: Defunct. AMA Ethics: Strengthened.

The Malpractice Crisis

The AMA, of course, faces other challenges. Malpractice flamed into a raging crisis in 1975, and again threatens to erupt. We created AMACO, our own insurance company, which stabilized reinsurance for physician owned companies. We stand prepared to do more, and we certainly must do more.

In recent years we have gone to court. Landmark lawsuits, against government to block intrusive regulations, against hospitals to curb exploitation of medical staffs and preserve the due process rights of contract physicians, and against chiropractors, who challenged our duty to warn against quackery, have all been won!

Indeed, the shape of the AMA has changed dramatically since our distinguished predecessors made that great decision more than 30 years ago, and we plunged uncompromisingly into the national political arena.

Yet, our primary commitment to the vast scientific and educational programs, which dignify the AMA and serve our patients, has never flagged. We have done nothing through it all but aim to enhance the quality of medical care.

We have fought to preserve a private health care system, and indeed, fought for professionalism and freedom. We have not failed. We must never fail.

Now the American Medical Association has reached another turning point. It is time to set the dimensions of our modern role and forge our new agendas. We have achieved much, but we must do more. There is no time for omphaloskepsis. (For those who may not share my pediatric surgeon's lust for things congenital, omphaloskepsis means the thoughtful contemplation of one's own navel.)

The American Medical Association's leading role in scientific matters is exemplary. Our Council on Scientific Affairs, for example, has prepared many learned dissertations on timely and important scientific subjects, such as infant nutrition, organ transplantation and alcoholism.

Our publications—**JAMA,** the specialty journals, **American Medical News,** and the countless books, pamphlets, news and magazine articles, media communications, and our library and computer services, reach thousands of physicians and untold numbers of the public each week. Our foreign editions reach more thousands in a dozen countries, in five languages, and above all, extend the hand of the American Medical Association to our comrades around the globe.

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BRIEF SUMMARY

INDICATIONS AND USAGE

For the prevention and treatment of nocturnal recumbency leg muscle cramps.

CONTRAINDICATIONS

Quinamm may cause fetal harm when administered to a pregnant woman. Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g) for attempted abortion In about half of these reports the malformation was deafness related to auditory nerve hypoplasia Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys Quinamm is contraindicated in women who are or may become pregnant. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PO) deficiency

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use Recovery usually occurs following withdrawal of the medication and appropriate therapy.

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever.

WARNINGS

Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision; however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin.

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PO deficiency in patients taking quinine Quinamm should be stopped immediately if evidence of hemolysis appears

If symptoms occur, drug should be discontinued and supportive measures instituted In case of overdosage, see OVERDOSAGE section of prescribing information

PRECAUTIONS

General

Quinamm should be discontinued if there is any evidence of hypersensitivity (See CONTRAINDICATIONS.) Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken. Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form. Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine (See Drug Interactions.)

Drug Interactions

Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

The effects of neuromuscular blocking agents (particularly pancuronium, succinylcholine, and tubocurarine) may be potentiated with quinine, and result in respiratory difficulties

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity

Drug Laboratory Interactions

Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used

Carcinogenesis, Mutagenesis, Impairment of Fertility

A study of quinine sulfate administered in drinking water (0 1%) to rats for periods up to 20 months showed no evidence of neoplastic changes

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test Intraperitoneal injections (0 5 mM kg) were given twice, 24 hours apart Direct *Salmonella typhimurium* tests were negative, when mammalian liver hemogenate was added, positive results were found

No information relating to the effect of quinine upon fertility in animal or in man has been found

Pregnancy

Category X. See CONTRAINDICATIONS

Nonteratogenic Effects

Because quinine crosses the placenta in humans, the potential for fetal effects is present. Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown Quinine in toxic amounts has been associated with abortion Whether this action is always due to direct effect on the uterus is questionable

Nursing Mothers

Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts)

ADVERSE REACTIONS

The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage (Individual or multiple symptoms may represent cinchonism or hypersensitivity)

Hematologic acute hemolysis, thrombocytopenic purpura, agranulocytosis, hypoprothrombinemia

CNS visual disturbances, including blurred vision with scotomata, photophobia, diplopia, diminished visual fields, and disturbed color vision, tinnitus, deafness, and vertigo, headache, nausea, vomiting, fever, apprehension, restlessness, confusion, and syncope

Dermatologic/allergic cutaneous rashes (urticarial, the most frequent type of allergic reaction, papular, or scarlatinal), pruritus, flushing of the skin, sweating, occasional edema of the face

Respiratory asthmatic symptoms

Cardiovascular anginal symptoms

Gastrointestinal nausea and vomiting (may be CNS-related), epigastric pain

DRUG ABUSE AND DEPENDENCE

Tolerance, abuse, or dependence with Quinamm has not been reported

OVERDOSAGE

See prescribing information for a discussion on symptoms and treatment of overdose

DOSAGE AND ADMINISTRATION

1 tablet upon retiring If needed, 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring

After several consecutive nights in which recumbency leg cramps do not occur, Quinamm may be discontinued in order to determine whether continued therapy is needed

Product Information as of October, 1980

Licensor of Merrell*

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

Direct Medical Inquiries to

Merrell

DOW

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Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.

getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate* Dospan* C IV

(diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain dlagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation." [2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate–it makes sense. And it's responsible medicine.

Merrell Dow

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References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed, New York. Raven Press, 1978, pp. 391-404.

Tenuate® C IV
(diethylpropion hydrochloride USP)

Tenuate Dospan® C IV
(diethylpropion hydrochloride USP) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personalty changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

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Cayey, Puerto Rico 00633

Direct Medical Inquiries to:

Merrell

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the AMA, our taproot of credibility and prestige. They must be strengthened as needed, and tailored to synchronize with evolving realities in a dynamic scientific environment, and preserve our preeminence in scientific matters.

The American Medical Association's traditional commitment to medical education must continue. I believe we have a duty to assure that all physicians are offered high quality, lifetime programs of learning, and I believe it is imperative to continue our responsibility for graduate and undergraduate medical education. We share this role now with appropriate fellow organizations. We must not relinquish that duty.

Freedom Is Vital

Given our fundamental commitment to scientific and educational missions, it is essential that we simultaneously protect the freedom so vital to professionalism, our stake in socioeconomics and politics is therefore boundless. We have taken the lead in a number of successful efforts, such as our cost commission project and the voluntary effort, and these are effective efforts, but they are only the beginning.

Our agenda for the 80s must include innovative and dynamic cost programs. If we do not affirmatively lead the private sector in cost containment, we will have that initiative torn from our grasp. We have one of the most effective lobbies in Washington. We are informed, straightforward, respected, and above all, credible.

And we must expand our legislative efforts for political pressures will assuredly increase. State lawmakers often point the way for national legislation. Myriad state laws affect health, sometimes in strange and conflicting ways. In Arizona, for example, the only state without Medicaid, we are embroiled in the development of a controversial indigent health care plan, an alternative to Medicaid which may have great national impact.

Therefore, I recommend that we aim to develop full capability to monitor and react to state legislative proposals, in conjunction with our state and local societies. Thus, acting as a true federation, we can greatly enhance both our national and state political influence.

These then are the elements of a new agenda for the coming years, a bold and venturesome agenda, scientific, educational, socio-economic, and political. Elements of necessity, and duty, drawn from the old, poised for the new, and adaptive to the vicissitudes of the time.

How must we proceed? We are strong, and we are healthy, but as we stand, we cannot fully meet all of the demands that inevitably will confront us in the balance of this decade. Therefore, I call for the physicians of America to join in a nationwide effort to build the organizational strength of the American Medical Association. And I propose a three-pronged program to achieve this goal.

First, we must build membership. Membership absolutely is the most important issue before us today.

Membership, the Lifeblood

Membership is the lifeblood of the American Medical Association. Members participate and formulate policies in the spirit of a working federation. And they provide dollars. Clearly we are no stronger than our membership, and our dollars. Although the Association has developed alternative sources of revenue and taken other prudent measures to enhance the financial strength of the organization, membership dues are still the primary source of our dollars. The best way for the AMA to increase revenue is to build membership.

We have undertaken a variety of membership marketing programs with considerable success. Our direct recruitment pilot study, for example, is encouraging, but inadequate. We must do more. Unfortunately, we suffer, as a federation, at the hands of some constituent societies that refuse to recruit members. For example, many practicing physicians simply have never been asked to join at any level.

It is imperative that we construct a situation to make membership at all levels of the federation—county, state, and national—so desirable that it will be unthinkable not to belong. I therefore recommend that all local and state societies immediately join the AMA in a continuing federation-wide membership recruitment campaign.

Second, we must build unity. We must further encourage our state and local societies to join in cooperative ventures with the AMA, such as membership, education, political activities and malpractice. They must be informed that stronger representation will flow from greater membership.

The specialty organizations are a valued component of the AMA. They speak for the particular interests of their members, which is proper and desirable. At the same time, the AMA is the only organization that effectively can represent the common interests of all physicians and their patients.

It is vital to have a balanced, healthy relationship between organizations. We should work together, draw from strengths, and bolster weaknesses. The underlying concerns of the AMA and specialty societies are inseparable. If we cooperate effectively, it will bear heavily upon the ultimate strength of medicine. An excellent example of common ground is the Joint Commission on Accreditation of Hospitals: an important commitment, badly in need of parental cooperation.

Other special groups in medicine must be solicited to build unity. Military physicians, women physicians, foreign medical graduates and academic physicians, for example, have certain concerns that can be addressed in the interest of strengthening membership. We should face the realistic problems of these groups and others fairly and objectively, and find ways to increase their involvement.

We have, however, at least one dazzling success in our membership situation: the students and house staff,

their numbers, and their voices have flourished. They are a vital, exciting complement to the AMA, and I believe we should fairly increase their representation.

There has been no better opportunity in the evolution of the Association to forge new and strong alliances between the organizations of medicine. It is time to resolve our differences with constructive discussion and negotiation and move forward together in a positive mode of cooperation. No one can doubt the need.

Pro-Participation

Finally, we must build participation. During my years in the House of Delegates and on the Board of Trustees, I have with enormous fascination watched the politics of medicine billow and fade, and I have developed a kind of smug and placid objectivity, found primarily in those who intend never in their entire lives to run for anything again. (Never.)

I humbly offer a few observations on participation. I am absolutely convinced that the American Medical Association will flourish so long as members participate to the utmost at all levels, and will fail if they do not.

Our process is democratic. Indeed, it is painfully democratic. But that pain must never vanish. We must always involve as many physicians as possible, and accurately reflect their wishes, however tedious that may be.

It is essential to have a healthy balance between our House of Delegates and its leaders. A functional and realistic system of checks and balances is crucial. The House of Delegates is the ultimate authority. There is no acceptable alternative to the participative democracy we now enjoy. If that system is weakened, it will impose a clear and imminent danger to the welfare of the AMA.

Clearly, the program I propose to build organizational strength demands simultaneous implementation of its three phases. Membership, unity and participation go hand in hand and build upon each other, just as the federation reflects the strength of all its parts. If we are to fulfill our new agendas, we must start from within.

My good friends—we are into the new decade of the 80s. America has a new President, a new administration, new commitments and assuredly will have new challenges. America also has fresh hope, boundless energy, and dauntless courage. For America, and for medicine, it is a time for renewal. Our task is brobdingnagian, but our goals are noble. I am confident we will succeed.

Alexis De Tocqueville once wrote:

"America is a land of wonders, in which everything is in constant motion and every change seems an improvement. . . . No natural boundary seems to be set to the efforts of man: and in his eyes what he has not yet done is only what he has not yet attempted to do."

In this land of wonders, in which we Americans are blessed to live, the profession of medicine is a cornerstone of freedom. . . . A freedom that must be preserved.

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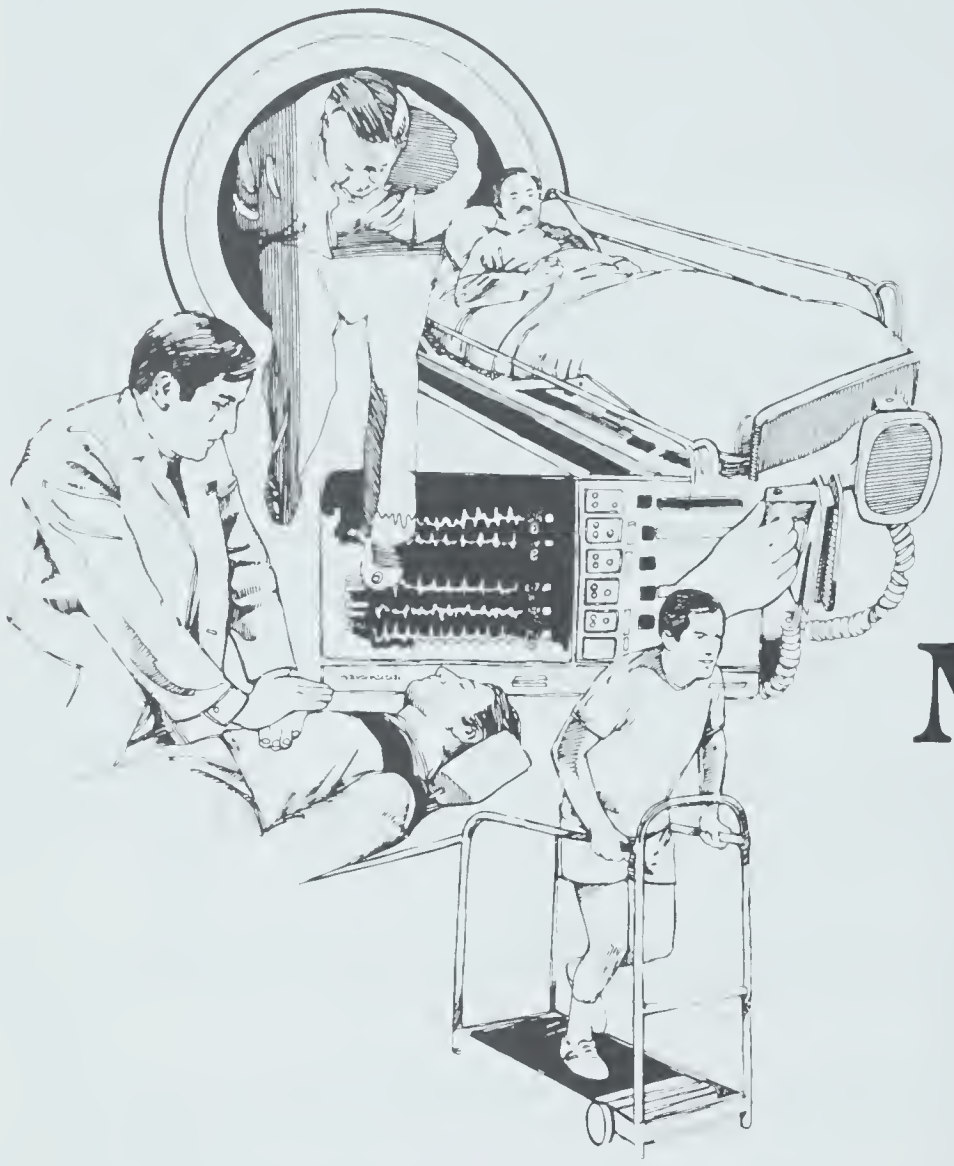


Explanation of Medicare Benefits (EOMB)

In June, The AMA Council on Medical Service presented to the House of Delegates its review of the history of the revision of the Explanation of **Medicare** *Benefits (EOMB) Form.*

The final revision will be effective on or before Sept. 30. Following are excerpts from the Council's report and comments, signed by John Glasson, M.D., Chairman, as received by the House:

In Report G at the 1979 Interim Meeting, the Council on Medical Service informed the House that it had received in May 1979 a draft proposal for a revised EOMB form, intended to provide more information to beneficiaries as to the handling of their claims for Medicare benefits.

At the same time, the Health Care Financing Administration proposed to change the explanation of the limit on Medicare payment and how the Medicare "reasonable charge" was determined.

As Report G stated, the Council pointed out to Medicare officials that language then in use in the EOMB form, though unsatisfactory, was more accurate and complete than the proposed new wording; that misleading statements on the EOMB form had in the past led to beneficiary and patient-physician misunderstanding; and that the language should be revised to provide a more accurate description of Medicare reimbursement limitations.

The Council called the attention of Medicare officials to the recommendation of Resolution 34, which called for an "addendum to the Explanation of Benefits to the effect that HEW's Medicare payments do not necessarily reflect actual, current prevailing charges in the patient's local area."

At the time Report G was presented, it was expected that no final revision of the form would be in general use before spring of 1980; in fact, the final revision was transmitted to Medicare carriers by Transmittal 834, dated December 1980, revising the Medicare Carriers Manual Part 3, effective on or before September 30, 1981.

The final version is, in the Council's opinion, much improved over the earlier draft. Many of the more complex Medicare limitations are more clearly laid out than in earlier drafts.

Of major interest to all physicians is the fact that the new EOMB form eliminates **all** references to either "reasonable charges" or "allowed/allowable charges," two phrases which have led to substantial friction between patients and physicians and between physicians and Medicare for at least the past decade. The phrase now being used is "Approved Amount," which, in the Council's opinion, is far more objective and less likely to cause misunderstanding.

When the "Approved Amount" is less than the amount billed, a statement will appear on the face of the EOMB form, immediately below the two differing amounts, as follows:

"(Item 3 on the back tells how we determined the Approved Amount.)"

The entire back page of the revised EOMB form is attached, for the information of the House.

The Council is aware that the explanations of the "customary charge" in 3.b. and the "prevailing charge" in 3.c. are still not completely precise; a median charge is not necessarily what the individual physician charges 50% of the time, and the 75% of customary charges (the

"prevailing charge") is oversimplified when described as "the amount charged 75% of the time." Similarly, describing the base year for calculations as "the past year" may lead to some misunderstanding.

However, the Council also recognizes that these concepts are difficult to express both clearly and concisely, and finds them a great improvement over the earlier draft which (as Report G indicated) spoke instead of the amount "usually charged" and gave no indication of the period on which the charge data was based.

The Council also wishes to call special attention to the fact that the addendum requested by Resolution 34 is incorporated almost verbatim at the end of item 3.c.

Therefore, while the Council will continue to monitor and seek improvement in Medicare communications to patients, as part of its ongoing responsibility, it believes that elimination of the "reasonable/allowable/allowed charge" language and the incorporation of Resolution 34 language should significantly decrease patient confusion about Medicare payment amounts. The Council expresses its appreciation to staff of the Office of Professional and Scientific Affairs, HCFA, who have worked with the Council the past two years to achieve these changes.

This report is submitted for the information of the House.

EXHIBIT Of The Back Of The EOMB
ALWAYS GIVE YOUR HEALTH INSURANCE CLAIM NUMBER AND CLAIM CONTROL NUMBER
WHEN WRITING ABOUT YOUR CLAIM. BRING THIS NOTICE WITH YOU IF YOU INQUIRE IN PERSON

1. YOUR RIGHT TO A REVIEW
   You may request a review of the determination on this claim if you do not agree with it and have not received an explanation which is satisfactory to you. If you wish to request a review, you must file a request with us. Write us at the address shown on the front of this form.

2. HOW YOU CAN USE THIS NOTICE
   You should keep and use this notice:
   a. As a record of your annual deductible.
   b. To show your physician or supplier how much of the annual deductible you have satisfied as of the date of this notice.
   c. As a record of the bills paid or denied on this claim.
   d. To claim insurance benefits under other health insurance policies. You may wish to make a copy of this notice before sending it to your private insurance company.

   If you lose this form you may ask us for a copy by calling the local or toll free telephone number on the front of this form.

3. WHY THE APPROVED AMOUNT MAY BE LESS THAN THE AMOUNT BILLED
   As your Medicare carrier, we determine for each medical service the amount Medicare may approve for payment to you or to your physician or other medical supplier. The amount Medicare may approve is determined by Medicare law and regulation. The approved amount for a particular service is the lowest of the following physician/supplier charges:

   a. The actual charge to you;
   b. The amount your physician/supplier charged 50 percent of the time in the past year to his/her patients, or customers;
   c. The amount charged 75 percent of the time by other physicians or suppliers in your local area. This charge limit can increase each year only by a percentage determined by the Government to reflect overall changes in the economy. Medicare's approved amount does not necessarily reflect the current actual charges in your local area.

   ASSIGNMENT: For claims taken on assignment, the physician or supplier agrees to accept the Medicare approved amount as the full charge and you are responsible only for the deductible, 20 percent of the remaining approved amount and any noncovered services.

   If you think the benefit is not computed correctly, you may request a review. (See paragraph 1 above.)

4. HOW MUCH MEDICARE PAYS
   For most covered services, Medicare pays 80 percent of the approved amount after your annual deductible is met. The deductible amount is mentioned on the front of the form and is your responsibility.

   If you have covered medical expenses in the last 3 months of a year that can be counted toward your deductible for that year, they can also be counted toward your deductible for the next year.

   For covered inpatient radiology and pathology services, Medicare pays 100 percent of the approved charge whether or not your annual deductible is met. Amounts paid for these services do not count toward your annual deductible.

   For covered outpatient services for treatment of mental illness, Medicare pays 50 percent of the approved amount after the deductible is met, subject to a $250 maximum in payments each year.

   The maximum payment for physical therapy services received directly from an independent practitioner is 80 percent of the first $100 of approved charges each year after the deductible.

   Under certain circumstances, the Medicare program can pay 100 percent of the approved amount for used durable equipment which is purchased. Lump-sum payments may be made for purchased durable equipment for approved amounts up to $600.

5. TIME LIMITS FOR FILING A REQUEST FOR MEDICARE PAYMENTS
   In order to receive Medicare benefits you must send in a claim within the following time limits set by law:

For services received	Send claims by
10/1/79 - 9/30/80	12/31/81
10/1/80 - 9/30/81	12/31/82
10/1/81 - 9/30/82	12/31/83
10/1/82 - 9/30/83	12/31/84

   These time limits may be extended if the delay in filing resulted from an error or delay by us, or by the Health Care Financing Administration. In such instances the claims must be filed within 6 months after the error is corrected.

6. FOR MORE INFORMATION ABOUT MEDICARE
   a. Check "Your Medicare Handbook"
   b. Write or call us using the address or telephone number on the front of this form. For out-of-area calls use the toll-free number shown on the front of this form.

What's happening here?

☐ Tissue Committee ☐ Surgical staff ☐ Record Review

☑ Mutual Assurance Claims Committee Meeting

Nobody knows more about Alabama physicians than Alabama physicians.

Mutual Assurance

DELEGATE'S REPORT
1981 Annual Meeting of the AMA House of Delegates

Following is a brief summary of the highlights of the AMA House of Delegates annual meeting in Chicago, June 7-11.

With 283 delegates, this was the largest house in AMA's history. Five state societies received an additional delegate seat due to membership increases.

The House postponed granting delegate seats to several additional specialty societies. The Board was asked to review the issue and report back.

The Reference Committee noted that there were many objections to granting representation in the house to organizations of sub-specialties with overlapping memberships. There are currently 56 national specialty societies with representation in the house.

REORGANIZATION AND DUES INCREASE

A major report of the Board of Trustees calling for a reorganization of AMA structure and staff and a $35 annual dues increase received the most attention. We approved most of the board's proposals and the dues for 1982 will be $285 for regular members. Dues for medical students and residents remain at $15 and $35 respectively.

In adopting a new functional profile for the AMA, the House called for **representation** of the medical profession to be the number one priority for the Association. Other primary functions are:

- Providing information, both scientific and socio-economic.
- Establishing and maintaining standards of conduct and performance.
- Sharing with other organizations the maintenance and implementation of educational standards.

In recognition of the special financial circumstances of new physicians and those in military service, the House adopted some dues incentives. We need to encourage physicians to join and become involved in organized medicine early in their medical career.

Young physicians in their **first** year of practice now pay 50% of the regular dues; and at the recent meeting the house voted to set the dues of physicians in their **second** year of practice at 75% of regular dues. Beginning in 1982, physicians in military service will pay two-thirds of regular dues.

DIRECT MEMBERSHIP

In a major decision with far-reaching implications for the strength and vitality of the AMA, we changed the bylaws to establish a direct AMA membership option. The AMA will put its first emphasis on recruiting members in cooperation with state medical societies that join with the AMA in a coordinated marketing campaign.

We learned that although AMA membership has increased in absolute numbers, there are still 241,000 physicians who do not belong. Of these, 178,000 also do not belong to state or county medical societies.

In addition to this direct membership option, we changed the bylaws so that direct members will be counted toward determining the number of delegates from each state society.

The AMA will bill all non-member physicians and medical students after the April 30 delinquency date each year. Lists of those physicians who apply for AMA direct membership will be sent for review to state medical associations before processing is completed. All objections to applicants for direct membership will be referred to the Judicial Council for prompt disposition. Accepted physicians and students will be urged to join state and county societies.

The House directed the Board of Trustees to submit a full review and reappraisal of the direct membership program after three years.

COMPETITION LEGISLATION

The House adopted a comprehensive report of the Board of Trustees pertaining to "pro-competition" national health insurance proposals now under consideration by the Congress. The Board with concurrence from the council on legislation and the council on medical service expressed some serious concerns with these bills and how these proposals would affect the way medicine will be practiced in the future.

The competition proposals would result in a shift in the way medical services are delivered. Currently, medical care is delivered through a decentralized market. These proposals assume that given a cost incentive, patients will accept responsibility for first dollar health care costs and choose a health insurance plan with fewer benefits. Consequently, it is assumed that the patient will be motivated to use fewer health care services.

The AMA believes that the likely result will be market concentration. The report said "sponsors of insurance plans, particularly under the more comprehensive competition models, would be expected to exercise their purchasing power to control selection of providers and facilities through special arrangements with them."

The House concurred with the Board's conclusion that the advocates of competition assume that patients are preoccupied with price and that assumption is yet to

be fully demonstrated. Accessibility, reliability, and quality are just as important—and maybe more so—than price.

In other actions, the House voted to:

- Request a Board re-evaluation of Association policies on health manpower and their relevance to current developments in physician supply, roles of allied health professions, medical education, and the health services market.
- Support the elimination of government funds for new start-ups of health maintenance organizations and for the termination of funds for other HMO's after completion of the current funding cycle.
- Endorse the concept of equal rights for men and women, but not the equal rights amendment.
- Recommend to hospital staffs that admission histories and physicals be performed only by physicians.
- Urge the food and drug administration to accelerate review of drugs on its "lacking evidence of effectiveness list."
- Urge the federal aviation agency to study medical emergencies on commercial planes and how they were treated with currently required medical kits.
- Support a bill that would place a moratorium on the federal trade commission's activities involving professionals.
- Oppose state laws making a physician's licensure contingent upon providing services to medicaid beneficiaries or any other specified category of patients.
- Have the AMA develop an educational program dealing with child molestation, incest, and exploitation of children.

Obviously, with so many items of business, I can only touch briefly on a few of major interest.

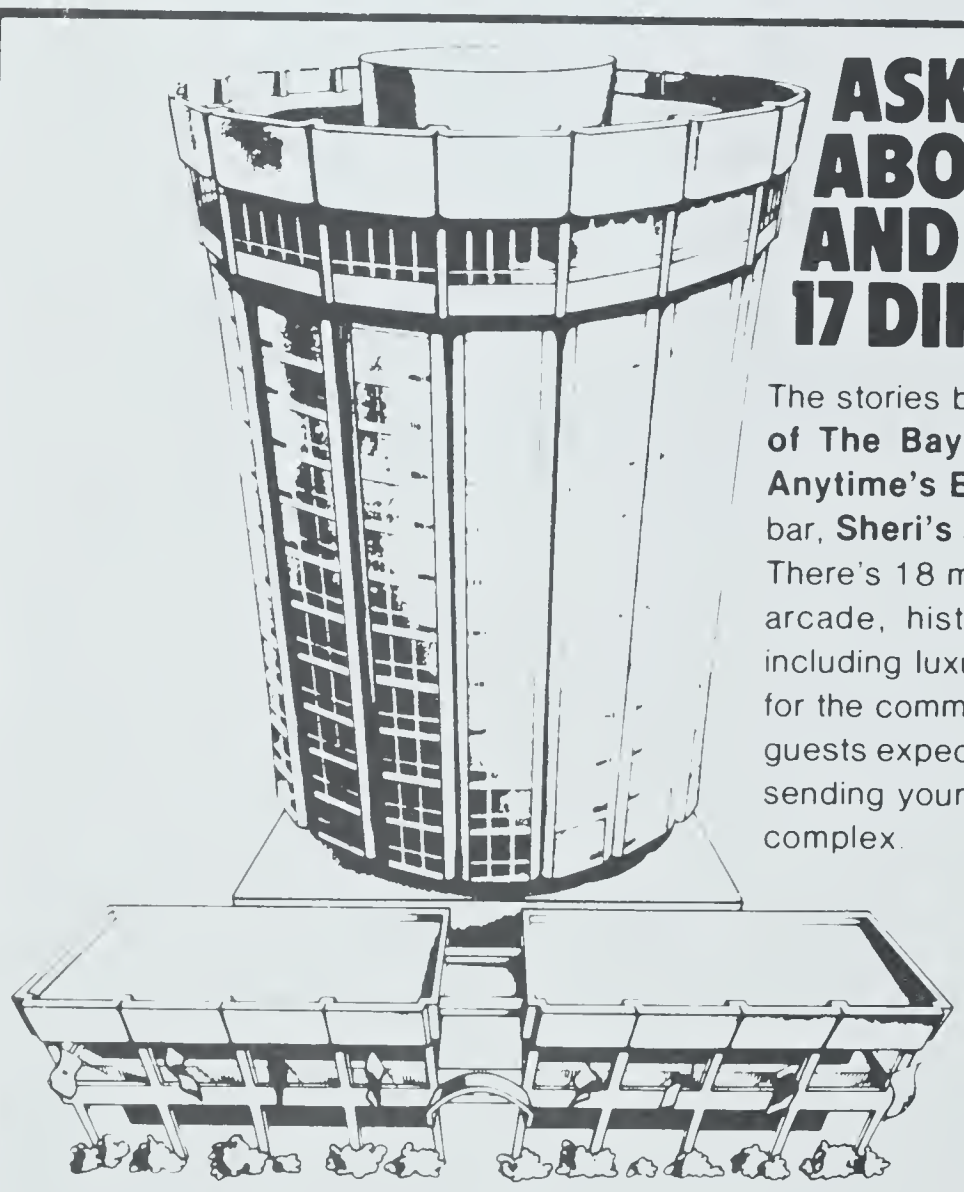
AMA House meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the Association may present testimony at the reference committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

If you can't come to the meeting you can still be represented through your delegate. Let your delegation know your opinions. You can also prepare a resolution and request that it be sumbitted to the house.

Many, many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

Thank you for giving me this opportunity to present this report.

O. Emfinger, M.D.
Union Springs



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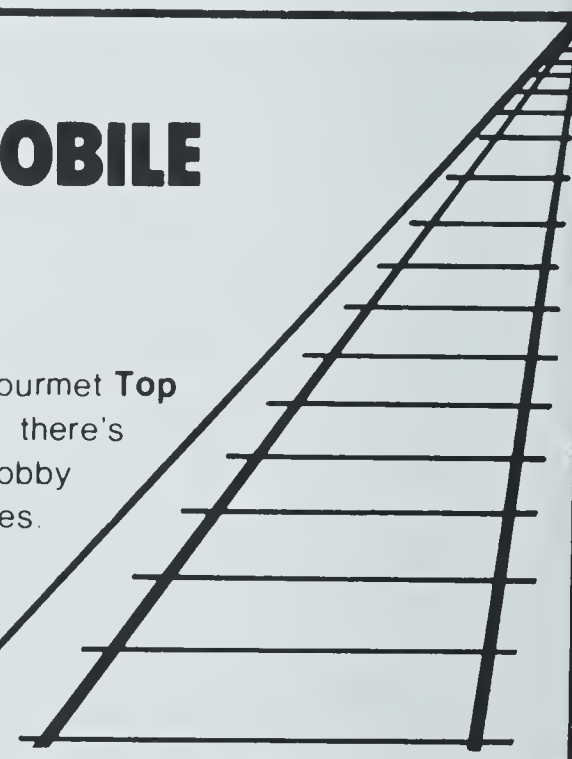

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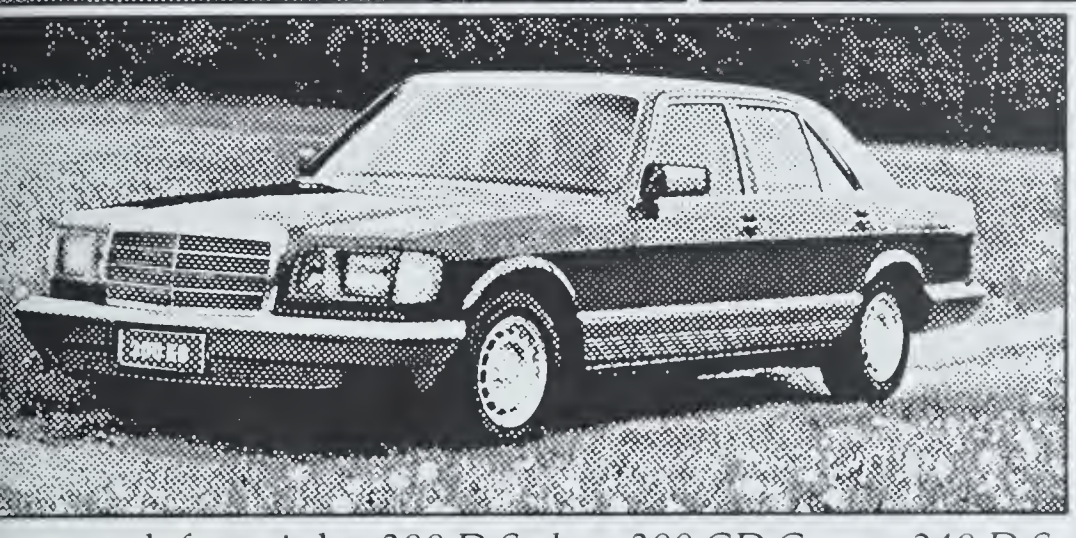

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FIFTY YEARS OF PSYCHIATRY

by
Claude L. Brown, M. D.

History needs no more justification than does one's breathing; both are immanent features of the individual. Any discipline interacts with its culture, and the history of both are firmly entwined. For instance: the rapid escalation of the malignancy of the Third Reich forced many Central European doctors to emigrate. The psychiatrists among them usually brought a greater psychodynamic understanding to the areas in which they settled. World War II produced many psychiatric casualties, necessitated facilities for handling such problems, and vastly broadened the acceptance and treatment of psychiatric illness.

Medicine is not a branch of the social sciences; neither are its practitioners often pure scientists. We practice, as Osler succinctly said, 'an art based on a science'. Psychiatry, more than any other aspect of medicine, connects the biological with the social functions of the individual and attempts to make sense of the entire person. That it does not always help the person, or even make sense of him in all cases, reflects our imperfections and need for further comprehension. Our very real dilemmas are not aided by harassing ourselves by asking if we are using the medical model, or the social model. I doubt that these pseudo-issues would trouble us if we doctors were not such self-flagellants.

Forty years ago over half of the hospital beds in the nation were occupied by the mentally ill. It is heresy even to wonder if the figures are different today—surely the hospitals are improved, the diagnoses are different, and the treatments are more effective. Into the 1940s and 1950s the average state hospital furnished mostly custodial care for the defective and psychotic. There were no drugs useful for other than temporary sedation; as it has been for at least two thousand years great reliance was placed on hydrotherapy; most hospitals were so overwhelmed by crushing financial difficulties that they were at pains to furnish food and clothing for their inmates. I recall a meeting in 1959 of the Alabama State Hospitals Board of Trustees (as it was then called) at which the crucial item of discussion was the monetary and logistical problems involved in getting several train-cars of Irish potatoes from Baldwin County to Bryce Hospital.

The Alabama Story

Alabama has been singularly fortunate in having as directors of its state hospitals several outstanding men. Dr. Peter Bryce, director of the state hospital at Tuscaloosa from 1860 to his death in 1892 was a widely respected psychiatrist. He was a member of the State Board of Health and State Board of Censors of the Alabama Medical Association; had been president of the Alabama State Medical Association and the American Medico-Psychological Association (which became the American Psychiatric Association), and was Vice-President of the Medico-Legal Society of New York. His national reputation was based on views on criminology, his policy of absolute non-restraint with patients, and his competence and integrity as a hospital administrator.

Also, he imported and planted at Bryce many trees, not native to the area; some still adorn the hospital grounds.

Dr. James Searcy, the next superintendent, continued the treatment program of Dr. Bryce. His son, Dr. George Searcy, working with Drs. E. L. McCafferty at Mt. Vernon Hospital and Dr. E. D. Bondurant at Mobile published in the Journal of the American Medical Association, in 1907, an article that established the nature of pellagra, and aided the recognition and treatment of this disease.

Dr. W. D. Partlow, valedictorian of the medical class of 1901 in Mobile, went to work at Bryce in 1902, became assistant superintendent in 1908, and superintendent in 1919, which post he kept until 1948. His clinical and administrative abilities were joined with a wide social awareness that focused on the needs of the mentally ill and defective. He led the organization of the Alabama Society for Mental Hygiene, which had its first meeting in his office at Bryce Hospital in 1915. To that meeting he brought Clifford Beers, the founder of the national organization and the author of the famous book, *A Mind That Found Itself.*

He was followed as Superintendent by Dr. J. Sidney Tarwater, who functioned most ably from 1948 to 1970. A widely respected, highly perceptive clinician and superb administrator, he did his best under what could be charitably termed difficult circumstances. He was the kindest of men, and the only person whom I have ever known or heard of who refused a raise in pay because he felt that the hospital patients needed the money more than he did.

Community Mental Health

With the impact of legislation implementing the care of mental patients, research into the causes and treatment of diseases, and drugs that could truly aid psychotic symptoms, the large hospital populations began to dwindle. In 1942 the Army Medical Corps established a department for neuropsychiatry; in 1946 the National Mental Health Act was passed, and in 1963 the Community Mental Health Centers Act passed. This extensive imput of federal funds and interest, augmented by state and local sources, reflected sweeping changes in the image held by the public of the mentally ill patient. Community Mental Health Clinics arose in many areas, decentralization of state hospitals increased, psychiatric departments in medical schools and other institutions enhanced their research and training of personnel. Many general hospitals designated an area for psychiatric services, and there developed smaller private hospitals. Usually after much struggle, coverage for mental illness began to be included in most hospital insurances contracts.

Beginning in the 1930s Cerletti and Bini began to use electroconvulsive treatment with schizophrenics, based on the observations of themselves and Meduna that symptoms disappeared for a while after the patient had a spontaneous seizure, and that patients with epilepsy rarely had schizophrenia. Experience shows that ECT is mostly beneficial in depression, although it is still used by some in acute schizophrenia. Intravenous metrazol, used at one time to induce seizures, has been abandoned due to the relative simplicity and safety of properly administered ECT. Insulin coma therapy, introduced by Sakel and considered in the 1940s as the best treatment for acute and subacute schizophrenia, has also vanished from the therapeutic list. Coma treatment required trained staff in constant attendance, was more dangerous than ECT, and was eventually seen to be no more effective. Like most good things ECT was enthusiastically and often inappropriately used. Although refinements in diagnosis, plus criteria for usage and techniques make it a beneficial therapy today, proponents often have to battle judicial edicts against its use.

Psychosurgery for mental patients began in 1935; Moniz received the Nobel Prize for demonstrating that severance of frontal lobe white matter could alter psychotic symptoms. In the United States this operation was popularized by Dr. Freeman and its use became widespread for the treatment of a variety of severe, intractable mental problems. Again, experience led to much more sharply defined areas of efficacy of this procedure. Being a physically destructive operation it is often condemned by the public and many psychiatrists. Balanced opinion shows it to be rarely indicated in carefully selected cases.

A tremendously beneficial development in the lives of many psychotics occurred with the advent in the 1950s of the phenothiazines. These agents, plus the more restrictively used lithium, have truly ameliorated the illnesses of countless patients. Antipsychotic drugs, chiefly the phenothiazines and butyrophenones, often curtail or diminish psychotic disorganization of thought and behavior with attendant increase in social and work capacity. They accomplished for psychosis what antibiotics did for infection—almost. For they were not proposed, and do not function, as curative agents. They get people out of hospitals, enable them to be treated without ever going to hospitals, and allow patients to be much more compatible with themselves and those around them. Phenothiazines surely do not work with all patients; they must be carefully used, for they are potent chemicals. But beyond doubt they have brought great surcease where there was great pain.

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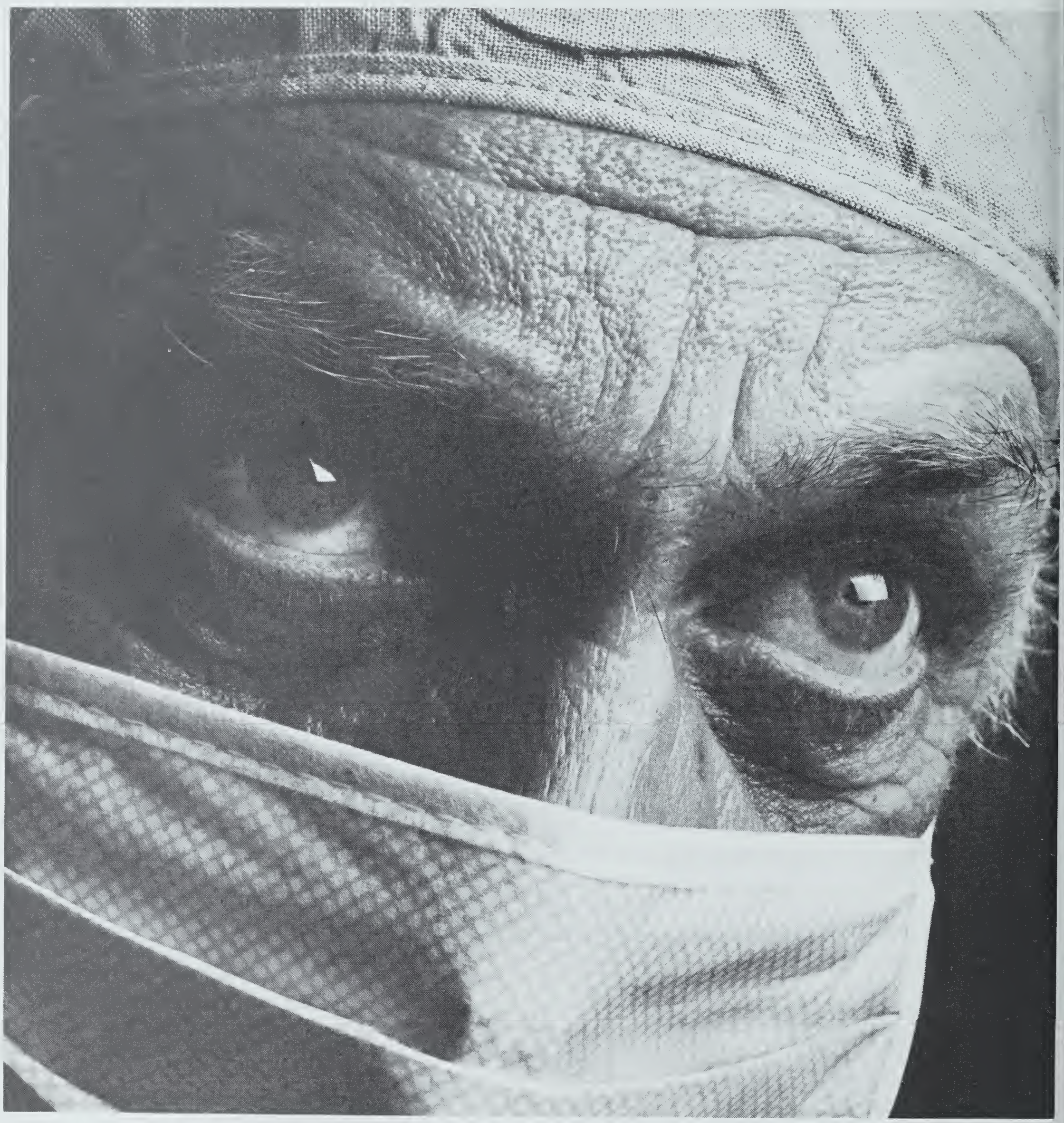

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are apt to have originated in a small community.[3,4,5] This study corroborates those earlier findings as the relationship between the resident's hometown (rural vs. urban) and his or her location decision was significant. (X^2 = 5.35, $p < .028$). The vast majority of the residents were married (87.0%) and approximately 55% of their spouses were from rural hometowns. Tests of the association between the spouse's hometown (rural vs. urban) and resident location, also revealed a significant association. ($X^2 = 5.78$, $p < .016$). Therefore, the second hypothesis was also supported, namely that there is an association between spouse and resident hometowns (rural vs. urban) and location preference.

Yett and Sloan[1] reported that location of the residency program is an extremely significant factor in influencing the physician's choice of practice location. This study also revealed a significant relationship between these variables ($X^2 = 7.82$, $p < .01$). Thus, the third hypothesis was also supported, namely that there is a relationship between location of residency program and practice location preference.

With the exception of the seven respondents who had not made a location decision at the time of the study, location preference (rural vs. urban) for respondents from each residency program is given in Table III. Additionally, Table IV presents a breakdown of location preference (rural vs. urban) by specialty area for each residency program. Further statistical analysis was not conducted due to the small number of respondents from each residency program.

Importance Scale

Table V contains a listing of the twenty-one variables along with their importance weights. The respondents ranked "acceptability of location to the spouse" as the most important factor in their location decision. This finding corroborates other results in the literature.[6,7]

Availability of adequate hospital facilities was rated as the second most important variable by the residents. Two other variables directly related to medical practice received high ratings as well—the opportunity to join a partnership or a group practice and the availability of other physicians.

The quality of the educational system in an area was ranked third on the importance scale and life style found in an area was rated as the fourth most important factor on the importance scale.

The remaining variables and their relative importance are listed in Table V. Ten variables were selected from the literature for the next analysis. These are displayed in Table VI.

Variable Rankings

An examination of the rankings shows a disparity between the two segment groups for three of the ten variables. Urban bound residents ranked "opportunity to join a partnership or group practice" significantly higher than their rural counterparts. (Mann-Whitney U = 123.5, p - value = .061) The difference in the rankings can in part be attributed to awareness by the rural segment that opportunities to join a group practice in a small community are fewer than those in an urban area.

To complement the above finding, an incongruence is evident between the two groups with respect to the opportunity for regular contact with other physicians. (Mann-Whitney U = 84.0 p = value = .003) Again, rural bound residents ranked this variable lower than the urban segment. The difference in this case can be attributed, in part; to an awareness by the rural segment that there are fewer physicians in a rural area and therefore the opportunity for regular contact with other physicians would be less.

Finally, the two groups differed with respect to their ranking of the factor "medical need in the area" (Mann-Whitney U = 1055, p - value = .018) In this case, the rural segment perceived medical need as being more important than the urban bound residents.

The results from Table VI are consistent with the importance scale generated earlier. The acceptability of location to the spouse and the availability of adequate hospital facilities received high ranking from both groups.

Residents' Perceptions of a Small Community

A major objective of this study was to evaluate the respondents' perceptions of a small town with respect to socioeconomic, medical/health characteristics, and quality of life factors. The profile generated in Table VII provides some insight into the differences between the two resident segments. A disparity can be seen between the groups for the variable "a physician's work is excessive in a small town." (t-value = -.34, 2 tail probability = .02) The ranking performed earlier found a difference between urban and rural bound residents' responses with respect to the opportunity to join a partnership or group practice. It is suggested that these findings are complementary and provide additional insight into the problems associated with a rural location.

Subsequent differences between the segments relate specifically to socioeconomic and life style variables. For example, the following variables, "a small town offers enough to satisfy a physician's social needs" (T = value = -1.88, 2 tail probability = .068) and "a small town offers a physician a slower paced, more personalized approach to living" (T - value = -2.32, 2 tail probability = .026) resulted in significant differences between the two segments. The same results occurred for the statement "small towns are the best place to raise a family" (T - value = -3.00, 2 tail probability = .005).

Responses to the statement, "a small town doesn't offer enough to fulfill my spouse's social, cultural and/or professional needs." (T - value = -1.84, 2-tail probability = .074) also reflected the differentiation between

TABLE IV

LOCATION CHOICE BY SPECIALTY AREA FOR EACH RESIDENCY PROGRAM

	Rural	Urban
Family Medicine		
University of Alabama in Huntsville — School of Primary Medical Care	1	1
University of Alabama — College of Community Health Sciences	6	2
University of South Alabama — College of Medicine	1	0
Carraway Methodist Medical Center	2	0
	10	3
Pediatrics		
University of Alabama School of Medicine	2	1
Lloyd Noland Hospital & Clinic	0	1
	2	2
Internal Medicine		
University of Alabama School of Medicine	3	6
University of South Alabama — College of Medicine	0	3
Carraway Methodist Medical Center	3	1
Baptist Medical Centers	0	1
Lloyd Noland Hospital & Clinic	0	1
	6	12
Obstetrics/Gynecology		
University of Alabama School of Medicine	0	3
University of South Alabama — College of Medicine	0	2
	0	5

TABLE V

RELATIVE IMPORTANCE OF VARIABLES INFLUENCING PHYSICIAN LOCATION DECISIONS

	%	Rank
Acceptability of location to spouse	82.0	1
Availability of adequate hospital facilities	76.8	2
Quality of education system for children	70.2	3
Life style found in area	68.0	4
Opportunity to join a partnership or group practice	63.8	5
Availability of practice coverage	55.3	6
Availability of other physicians	51.1	7
Opportunity for regular contact with other physicians	48.9	8
Climate or geographical features of area	46.8	9
Access to continuing education	42.5	10
Family and/or friendship ties to area	42.5	10
High medical need in area	36.1	12
Cultural advantages	29.8	13
Possibility of regular work hours	29.8	13
Availability of recreational & sports facilities	29.6	15
Income and/or financial start-up incentives guaranteed by a community	25.5	16
Income potential	21.2	17
Opportunities for social life	17.0	18
Prospect of being influential in community affairs	12.7	19
Population of the community	10.6	20
Payment of forgiveness loans	4.3	21

the two segments. As established previously, the spouse contributes greatly to the location decision. This is likely to account for the urban bound residents agreeing with the statement moreso than the rural bound residents.

Finally, the resident profile differentiates between the two segments for the variable "small towns have an adequate educational system" (T - value = -2.21, 2-tail probability = .033). The urban bound segment disagreed with this statement and perhaps reflects the negative preconception many people have with respect to rural school systems.

Discussion

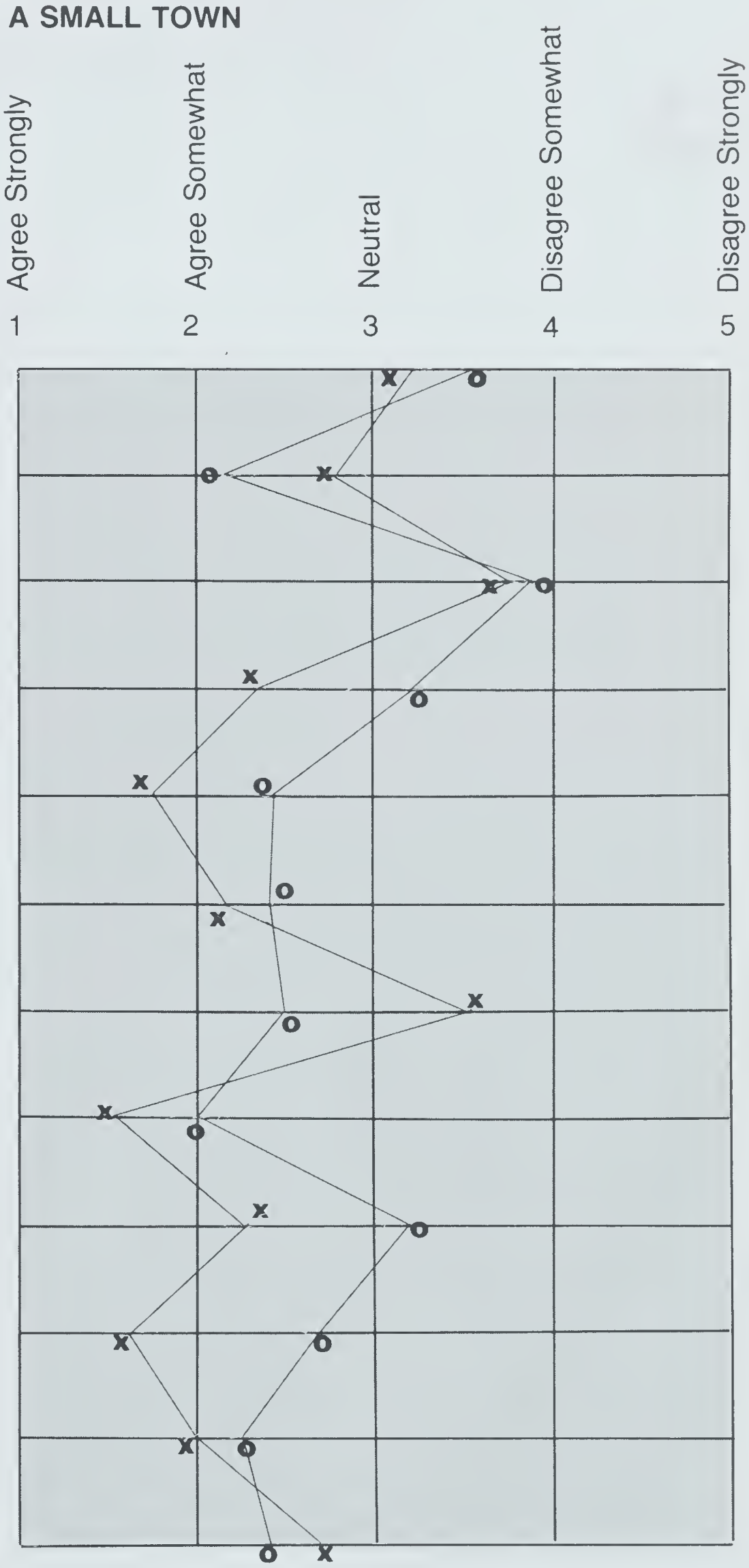
This study indicates that the four variables ranked by Alabama's primary care residents as the most important influences in a practice location decision are: 1) acceptability of location to the spouse; 2) availability of adequate hospital facilities; 3) quality of education system; and 4) life style.

With the exception of Cooper's *et al* study,[3] the acceptability of the location to the spouse is regularly cited in the literature as having a great deal of influence in the decision making process. In fact, this particular factor seems to be increasing in importance, perhaps in part due to the increasing number of marriages in which both partners have professional careers and locations must be more carefully scrutinized as a result.

The availability of adequate hospital facilities has been rated as a key factor in physician distribution throughout the literature. A hospital practice enables a physician to provide more varied and complex services without incurring an accompany increase in overhead

TABLE VII

RURAL AND URBAN RESIDENTS' PERCEPTIONS OF A SMALL TOWN



A small town has adequate hospital facilities

A physician's work is excessive in a small town*

A physician's income is limited in a small town

A small town offers enough to satisfy a physician's social needs**

A small town offers a physician a slower paced, more personalized approach to living*

A small town offers an adequate amount of recreational activities

A small town doesn't offer enough to fulfill my spouse's social, cultural and/or professional needs***

It is easy to get involved in community affairs in a small town

Small towns have an adequate education system**

Small towns are the best place to raise a family*

Suitable housing is available in a small town

There are not adequate shopping facilities in a small town

*Significant at the .01 level
**Significant at the .05 level
***Significant at the .10 level

X = rural
O = urban

cost. As Rosenblatt and Moscovice[8] point out, the absence of a hospital in a rural community frustrates the physician's ability to fully use his or her skill and deprives the physician of a source of income that may be critical to his or her financial success. Further, although the purpose of the study did not include addressing the merits of maintaining small, rural hospitals, this finding is inherently a component of that issue and must be considered when solutions to the maldistribution problem are proposed.

The quality of the educational system found in an area was ranked as the third most important factor in the location decision. Seventy-six per cent of the respondents are parents and the researchers suggest that this factor's position on the importance scale is a reflection of the emphasis which professionals generally place on quality education for their children. Consequently, stereotypical attitudes and impressions about rural school systems are often a deterrent early in the decision process when rural locations are being evaluated. Assurance that quality education is available must be provided a physician and his or her spouse for a particular location to be given serious consideration.

TABLE VI

MANN WHITNEY U TEST RESULTS FOR URBAN AND RURAL GROUPS

	M-W Test		
	Rural	Urban	P-Value
Climate or geographic features of area	9***	8	1.00
Life style found in the area	6	6	.392
Acceptability of location to spouse	2	2	.441
Opportunity to join a partnership or group practice	5	1	.061*
Opportunity for regular contact with other physicians	8	4	.003**
Availability of adequate hospital facilities	1	3	.996
Availability of practice coverage	7	5	.107
Quality of educational system for children	3	7	.468
Income potential	10	10	.686
Medical need in the area	4	9	.018*

*Significant at the .10 confidence level
**Significant at the .01 confidence level
***A "1" designates the most important variable influencing a resident's location decision, whereas a "10" indicates minor importance in the location decision.

Life style found in an area was ranked as fourth on the importance scale. Although this variable is a highly personalized factor in the decision making process and is wrought with preconceptions about both rural and urban living, its location on the importance scale is significant to this study. Since it is ranked fourth and is followed closely by "the opportunity to join a partnership or group practice" and "the availability of practice coverage" it may be inferred that these three factors are interrelated and must coexist for a location to be appealing to a physician. Realistically speaking, very little can be done to alter a physician's life style preferences. However, a number of studies have found that physicians practicing in rural areas tend to have rural roots and this study corroborates those earlier findings.[3,4,5] Of the respondents who were going into a rural area to practice, 72.2% had spent the majority of their lives in a rural area and 66.7% of those locating in an urban area had roots in that type of location.

The question one might logically ask at this point is what does all of this mean for Alabama, and specifically rural Alabama? Unfortunately only 38% of all respondents who chose a rural location, chose a rural Alabama community. More than three fifths of the rural bound primary care physicians chose a location out of state. Additionally, of all the respondents staying in Alabama to practice, only 24% located in rural areas of the state. It should be reiterated that the study included primary care residents exclusively and these are the specialities that are best suited for rural practice. Yet, only one in four of the respondents chose a rural Alabama location.

This study also revealed an encouraging statistic in the area of family medicine. Ten of the 13 respondents graduating from family practice residency programs chose rural locations. Apparently, the state's continued emphasis on training family practitioners for rural practice has had an impact and is one appropriate means of addressing the maldistribution problem.

Although the response rate for this study was smaller than is ideal, the authors feel that the findings are significant and indicative of the reality of this complex issue, particularly since the study's total population was only 110 individuals.

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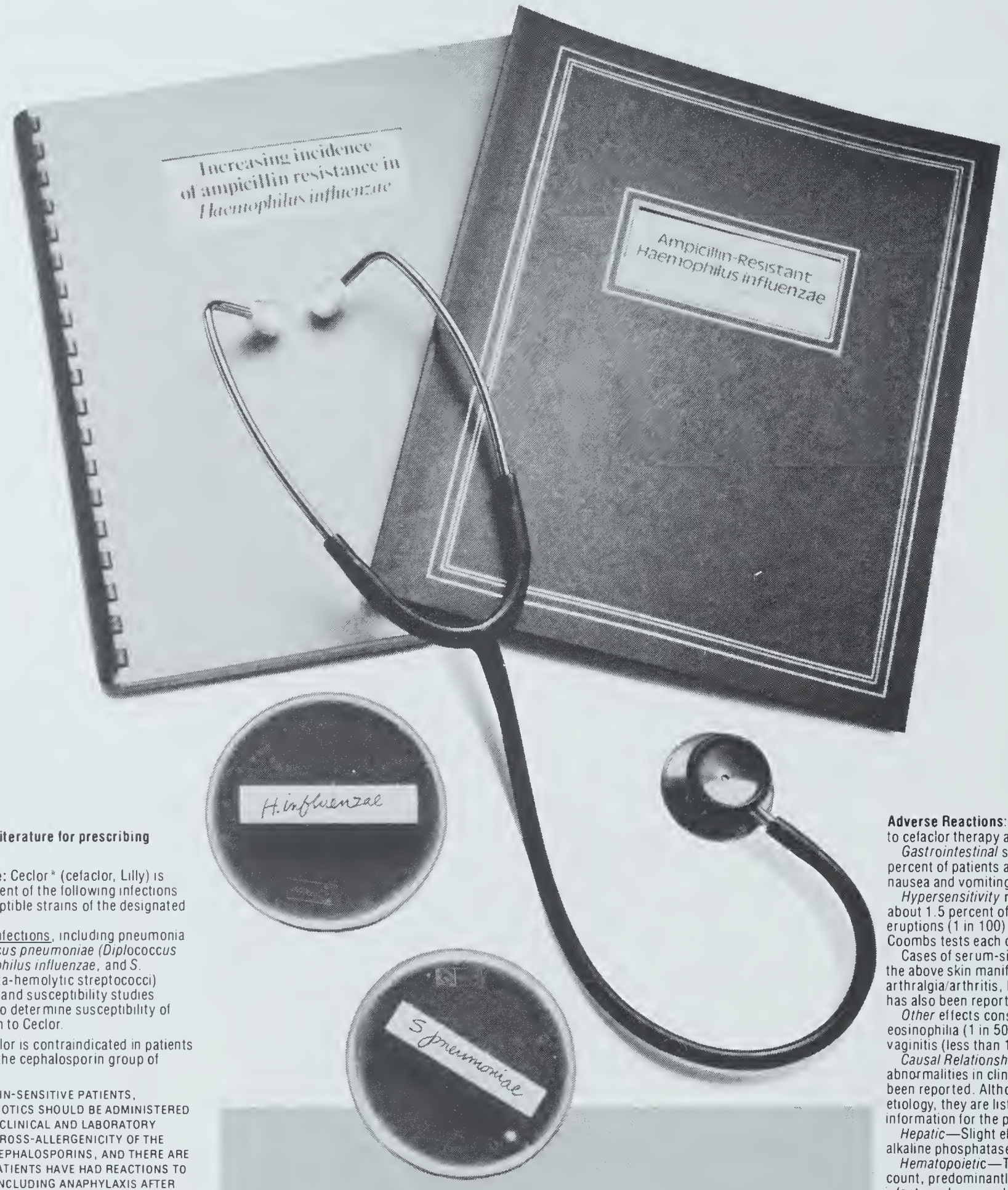

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Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

100061

Mrs. Rufus E. Lee, Jr.
President, A-MASA

STRESS IN THE MEDICAL FAMILY

"Why pay the price of hatred when a little dislike will do he job? Why go into orbit with anxiety when nervousness will take care of the situation? Why depression when a little sadness is enough?"[1]

We have been trained or trained ourselves to believe that if we don't smoke, drink no more than two drinks a day, and stay within our ideal weight we we live a happy, healthy life. Not true!

There is an old problem that we are just learning to believe in as a real medical disorder. Stress! It is probably the most deadly of diseases and has been linked to depression, coronary heart disease, peptic ulcers, suicide, asthma, diabetes, multiple sclerosis, cancer, drug abuse, etc.

A Nebraska Cardiologist, Dr. Robert S. Eliot, has reported that stress is now the No. 1 cause of coronary heart disease and states that in 1981, coronary heart disease will kill more than one million Americans, half of whom will die suddenly. Twenty-three percent of those who die suddenly will do so on Monday morning. Could stress be the culprit? What is this phenomenon?

The Committee on Stress, Strain, and Heart Disease of the American Heart Association, after much deliberation, has defined stress as: (1) any stimulus, physical or emotional, internal or environmental, that evokes a response by the cardiovascular system; (2) Strain is the response of the cardiovascular system to such stresses or stimuli.

There has been so much advice on what should be done to avoid stress—from taking Vitamin C, correcting dental bites, to Dr. Fox Kronas' low-fat, moderate protein, unrefined carbohydrate diet. These all seem a little far-fetched to me, but if it works, I'm all for it.

A physician has a lifestyle that presents a set of strains on the cardiovascular system that the outside world could never understand. For instance, he must change his pace or attitutde every 5 to 30 minutes to fit the needs of the patient he is speaking with or operating on at the time. He sometimes has the unpleasant task of telling a person he cannot help them or their family member. He knows they are begging for an answer that he cannot give. What a cardiovascular response that would cause! Thankfully, most of the time the physician can help and that is the plus side of stress.

The doctor *and his entire family* are expected to have answers to everyone's problems, not only in the office, but at social gatherings, at church, or restaurants. More strain.

We are told to relax more and I'm sure it would help but how? Most doctors think of relaxation as a state of complete exhaustion. We get so accustomed to being nervous and tense we don't know we aren't relaxed. Relaxation is freedom from tension and some very good guidelines are even-temperedness, acceptance, being alert but not nervous.

Love or the lack of love can cause a plus or minus. Dr. George Vaillant says a physician has a particular need for love and acceptance and they relate that need to depressive personalty structures. Physicians often feel it is a weakness to call on family or friends for support. The only remedy that comes to mind for this is open communication. We all need to be able to show love and concern for each other and we also should feel free to say "Hey, I need help" or "I need *you*". Many times the reaction is anger because we fail to identify our real problems or those of our spouse. When we have reached "overload" it is especially hard to communicate and it takes conscious effort to reverse our feelings but the reward is worth the price.

Doctors, we the Medical Auxiliary, would not exist without you. We are your spouses and we fell in love with you some years ago. The one thing that can add substantial anxiety to our lives and yours is the feeling that maybe some of that love has faded. There are so many things to take the place of our communications that are unavoidable—your practice, our children, aging parents, financial matters, new homes, inflation, etc. However, we can turn off the television occasionally, go out on the porch or patio and hold hands. We can go out on a date every Thursday night and discuss pleasant

Continued on next page

subjects, future plans (there is still a future) and love. How about a vacation without the children?

Let's take time to "smell the roses," to look at each other the way we did when we were first married and to touch. If necessary, schedule time together as you would schedule a patient. It's very hard to feel stress under these circumstances.

I know we can't remove the problems but we can change our reactions to them and thus diminish their effect. We are responsible for our own stress management and our reactions to challenge and overload.

Physical activity is truly a great healer of stress and most of us are guilty of ignoring that necessary part of our body needs. Although tennis and golf are great sports, they may add additional stress to a very competitive person. Walking or jogging could be the perfect answer. Fifteen to thirty minutes a day provides enough physical excercise and adds the bonus of time to think without interruptions. When I can discipline myself to get up early and walk for a few minutes my whole day goes better. There are the same strains and stresses but after a little exercise and time to communicate with my God, together we solve a lot of problems before they happen.

Mary Julia Lee

[1]Eliot, Robert. Address given at American Medical Association Auxiliary Convention.

Dr. Blair and the Black Widow Spider

Continued from page 22

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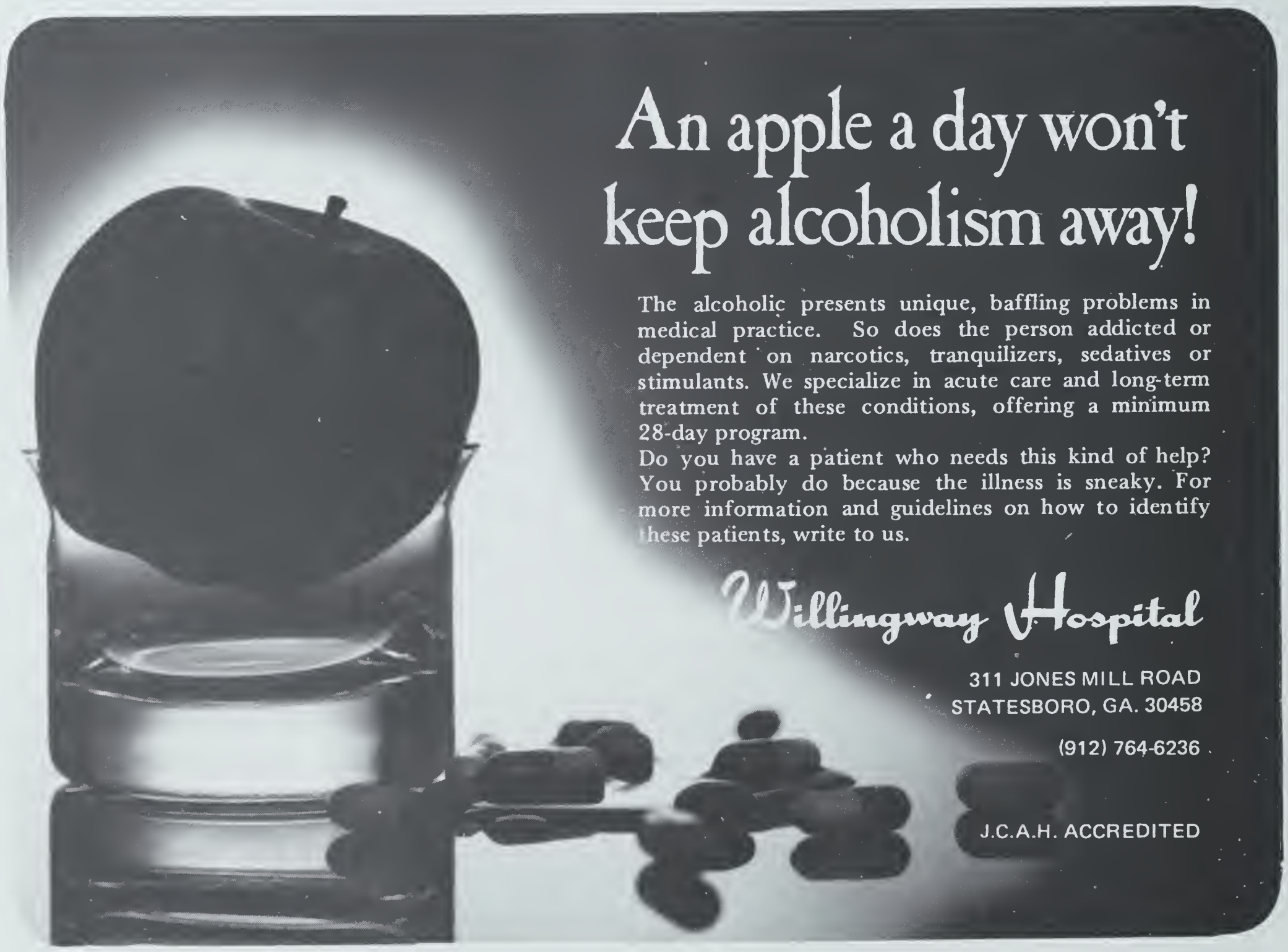

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General*: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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ROCHE LABORATORIES
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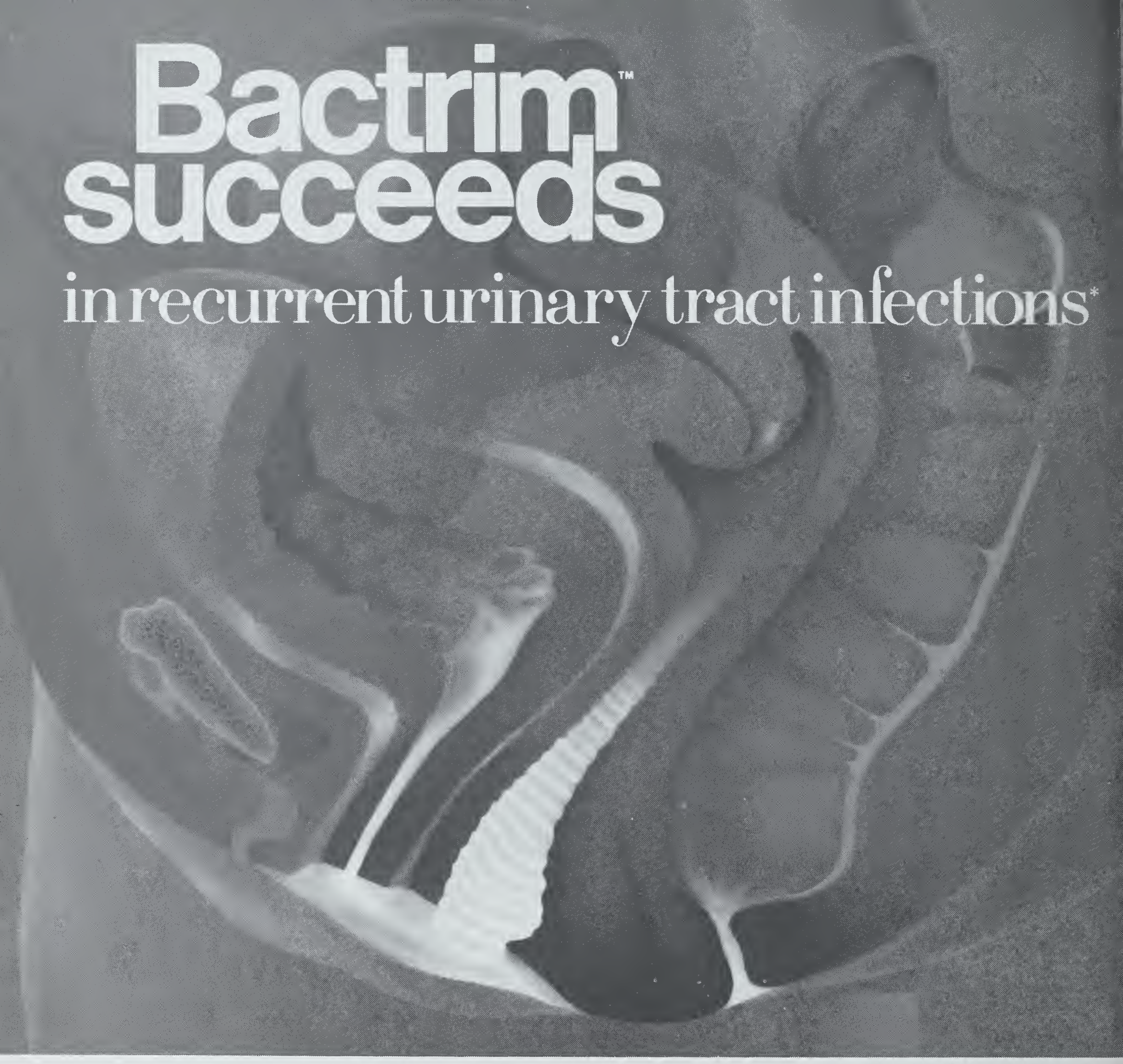
Bactrim™ succeeds

in recurrent urinary tract infections*



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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

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Bactrim™ DS

160 mg trimethoprim and 800 mg sulfamethoxazole

DOUBLE STRENGTH TABLETS

maximizes results with B.I.D. convenience

ROCHE®

*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

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War of the Roses in Union Springs

See page 9

Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months)
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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The *Stylebook/Editorial Manual,* published by the AMA, is the general reference for questions of style. It is particularly useful in the proper presentation of data. Available at cost ($6.50) from MASA. When conflicts occur between usage, etc., by an author and the stylebook, these will be resolved in favor of the author if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* by William Strunk Jr. and E. B. White, which emphasizes brevity, vigor and clarity. Available at cost ($1.65) from MASA.

Final authority on grammar is Webster's *New International,* Unabridged, Second Edition.

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Spreading the Word

President J. Kendall Black, Jr., M. D., impresses me as having discovered the secret of perpetual motion. Not only is he the *youngest* MASA president in this century; he must surely be the most *restless*.

He has had speaking engagements before local societies in every part of the state, with more to come. Just look at his fall schedule:

Sept. 8, Jackson County Medical Society, Scottsboro; Sept. 14, Shelby County Medical Society, Alabaster; Sept. 15, Lee County Medical Society, Opelika; Sept. 17, Etowah County Medical Society, Gadsden; Sept. 28, Monroe County Medical Society, Monroeville; Oct. 6, Houston County Medical Society, Dothan; Oct. 13, Chilton County Medical Society, Clanton; Nov. 2, Medical Society of Montgomery County, Montgomery; Nov. 3, Marshall County Medical Society, Guntersville; Nov. 9, Winston County Medical Society, Haleyville; Nov. 10, Talladega County Medical Society, Talladega; Dec. 15, Covington County Medical Society, Andalusia.

And he has already spoken in Cullman, Tuscaloosa, Anniston, Mobile, Athens and Russellville to medical societies, plus many appearances before other medical groups, auxiliary, medical assistants, etc.

MASA General Counsel Jack Mooresmith and I go with Dr. Black on these trips, which have a single theme: Organized Medicine: Its Strengths, Limitation and Future. I usually outline the strengths and bring the doctors up to about the time of the portentous *Goldfarb* decision; Jack tells them about all the legal minefields out there; and Dr. Black looks to the future with his infectious enthusiasm for the struggle.

The word Dr. Black is spreading is the medical gospel: We are living in an age of consumerism in which American medicine seems to be fair game for everyone, from the Naderesque groups, through Congress, the Courts, politicians, FTC and other regulatory agencies, and assorted other hecklers and enemies.

It is a time, if there ever was one, when every single doctor in the land must join the fight to preserve the independent practice of medicine. Physicians who think it's not their fight are living in a fool's paradise. Letting George do it just won't pass muster any more.

On the other side of the coin, societies that are content to rock along in an old country club spirit, without aggressively recruiting every physician in their county, are living in a distant past when the threats to medicine were remote and dimly seen.

They are very real now. They are clear and present dangers that will not respond to the ostrich approach. The preliminaries are over; this is the main event.

Total organization and unity of purpose were never more vital than now, Dr. Black is trying to tell you.

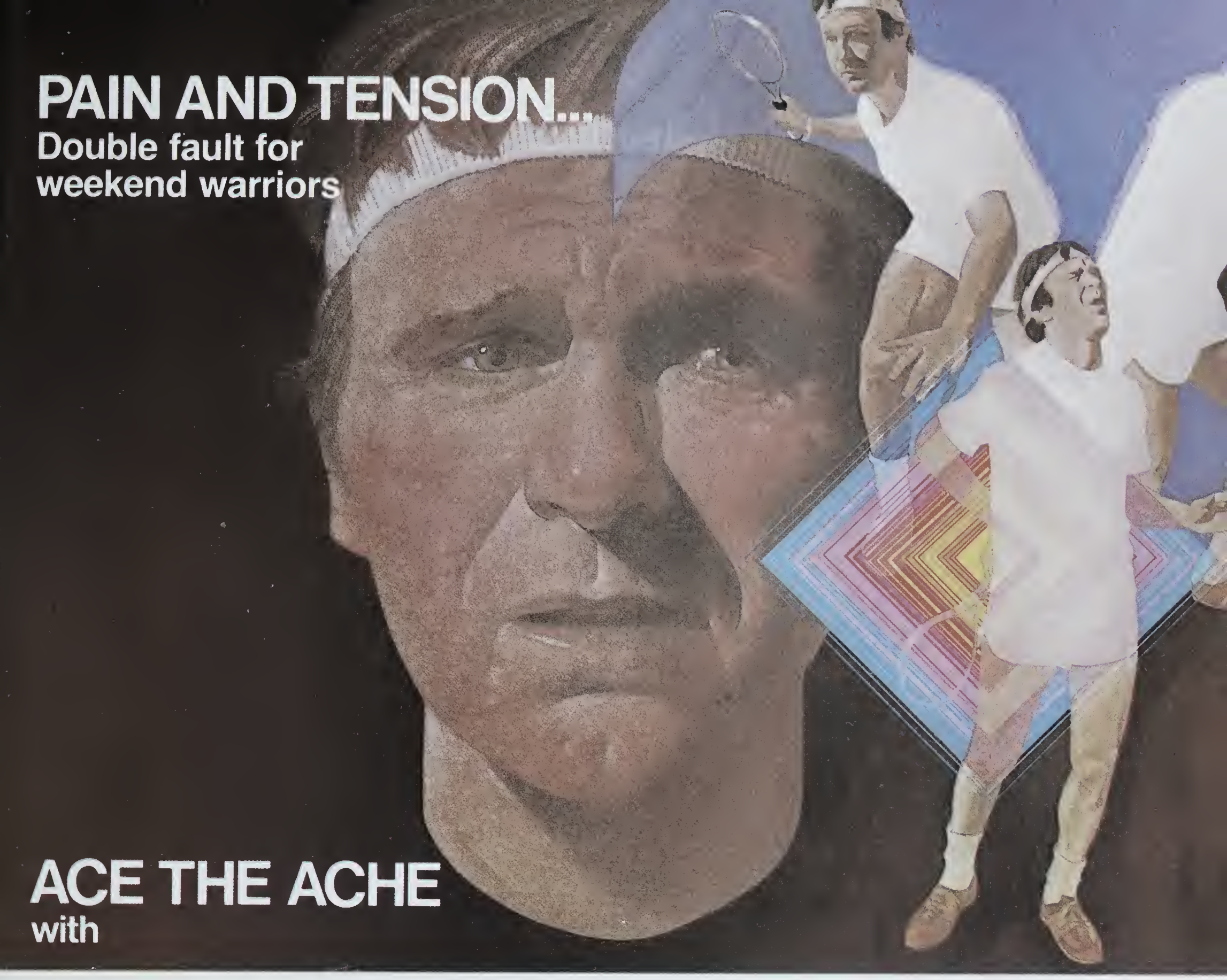
He sincerely believes, as do Jack and I, and every member of the Board of Censors, *that in this decade the independent practice of medicine is going to stand or fall, survive or perish, sink or swim.*

Which of these it does will, in a very real sense, depend on top-to-bottom organization and involvement of all of you.

That is not scare talk, not crying wolf: it is the reasoned judgment of all of the officers you have elected to represent you and of entire stewardship of the American Medical Association as well.

If you are not concerned enough about your own interest, surely you think enough of your obligations to posterity to help preserve for future generations of physicians, and the public, a system that has brought the best health care to any people anywhere in the history of the world.

S. Lon Conner
Executive Director



Equagesic®(IV)

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

*__INDICATIONS__: Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information, FDA has classified the indications as follows.
"Possibly" effective, for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be towered with resultant slowing of reaction time and impairment of judgment and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication

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Philadelphia, PA 19101
TM

for mild to moderate pain

Wygesic®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e g driving a car or operating machinery Patients should be cautioned accordingly
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea and vomiting These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine
MANAGEMENT OF OVERDOSAGE: SYMPTOMS
The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects
Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported
Ingestion of 10 grams or more of acetaminoohen may produce hepatotoxicity A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I V , simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e.g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions
Oxygen, IV fluids vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended.

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J. Kendall Black, Jr., M. D.
President

PRESIDENT'S PAGE

Medical Assistants

During this year I have had the opportunity to represent MASA at various health related functions across our state. The first weekend in August Brenda and I had the opportunity to meet with a group of individuals that essentially bridges the communications gap between the physicians of Alabama and the patients whom we serve.

This group is the Alabama Chapter of the American Association of Medical Assistants. This is an organization that has been functioning in our State for approximately twenty-five years and this year, as in many past years, the President of our Association has the privilege of addressing its membership during their annual seminar. In fact, many of you may remember that at our annual session last year we passed a resolution commending this organization for its work in continuing education.

I have had the opportunity to address this group not only on this occasion but on one previous occasion and while I am speaking to them I am also learning from them. I have found that they are not only concerned with earning a living but primarily with serving our patients. I further have recognized that they are committed to self-development and life-long learning.

As I spoke to this group addressing the issue of quality assurance and cost containment, it occurred to me that I was indeed most likely speaking to some of, if not the most important cost containers and risk management personnel found in any physician's office.

For it is the medical assistant in the physician's office that must deal with third-party billing, purchasing vendors and indigent patient care needs. These individuals are the first and last persons to see the patient in the office and are in a unique position to reflect the philosophy of the office and set the tone for everything that happens therein.

Their direct and indirect influences in the physician/patient relationship can either enhance it or stain it. Their actions may have a direct bearing on the outcomes of treatment as well as the socio-economic and medical/legal actions encountered by physicians. And as I have come to realize more and more that these are the first line troops in the patient/physician relationship, I recognize that it is becoming increasingly important that we as physicians see that our medical assistants are well trained and that their education continues.

Medical assistant workshops, risk management workshops, cost containment workshops and quality assurance programs are available for these individuals. In these days of increasing thrusts by third parties and outside intervenors between the physician/patient relationship, our medical assistants are invaluable. It is in our best interest to see that they are well trained, fairly paid and well treated.

Additionally, the information they can impart to you regarding new techniques are often timely and frequently useful in your practice management programs.

I urge you to see that your office personnel are members of and active in the American Association of Medical Assistants (Alabama Society).

P. S. Stay tuned next month for an up-date on our cost containment efforts. The committees are organizing and their activities are increasing. With health care costs exceeding the national average by a substantial margin each month it is time to get cracking.

/Kendall

J. Kendall Black, Jr., M.D.

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PROFILE

WAR OF THE ROSES IN UNION SPRINGS

by William H. McDonald

The only desideratum Orlzaba Emfinger, M. D., has missed in 30 years of surgical and general practice in a small town is a good history of England before the time of Alfred the Great.

But since the good King Alfred ruled in the 9th Century, before which there simply wasn't any reliable historical recording in England, Union Springs can't be faulted for not having that. For that matter, no history exists in Montgomery, Birmingham, Atlanta, New York, London or Paris.

Dr. Emfinger came by this kind of curiosity honestly. As an undergraduate at Birmingham-Southern, the son of a Baptist minister, he majored in History and Political Science, minored in Economics.

To the frequently asked question, "What kind of pre-med course preparation was *that*," Dr. Emfinger has a two-part answer: (1) At the time, he hadn't thought of becoming a doctor; and (2) more pre-med students *should* take liberal arts courses, leaving most of the science for medical school, an argument that is currently being renewed by deans of medical schools.

But Dr. Emfinger has benefited enormously by this early and continuing interest. It has helped him as AMA Delegate to see the forest for all those trees; in his work as Chairman of the Council on Legislation, often the point man before the state Legislature; it has sustained a lifetime of reading everything he can get his hands on about English history, and, more recently, American history, notably the Civil War period.

Poverty Pocket

In 1951, when Dr. Emfinger set up his practice in Union Springs after a year in Opp, Bullock County was the 10th poorest county in the United States. Times are better, but it hardly ranks even today with Westchester County, or some of the other more affluent regions in the land.

Born in Greensboro, Florida, in the north central part of that state, Orizaba was six months old when his family moved to Birmingham, where his father was a mining town pastor. They moved to Uriah when the young Emfinger was five. He was raised there in Monroe county, near Atmore.

Dr. Emfinger

In high school he decided the good life was that of a gentleman farmer. Having picked too many bales of cotton and too many wagonloads of velvet beans, he didn't care much for the laborer's lot. He got into medicine by accident. While at Birmingham-Southern, he took a part-time job working with TCI's famed health department, one of the earliest examples of industrial medicine. He began putting in two nights a week at one of the district health offices, which were manned around-the-clock. That evolved into a full night-time job. He had a place to study and sleep and the pay was better than nothing. Duties included a kind of watchman role, with responsibility for summoning the doctor or ambulance when necessary at any hour.

Through the TCI job, he became acquainted with two young physicians and an older one. Although studying Economics, History and Political Science at the time, he decided to make the switch to pre-med.

A Year Out

About this time, his father became seriously ill; the family needed his help. Although he had received no college help from home, now they needed his support. He had to drop out of school for a year to work at Moore-Handley, while still moonlighting at TCI. After a year, he resumed his studies, eventually being forced to finish a summer course in organic chemistry to qualify for medical school.

In Union Springs, Dr. and Mrs. Emfinger live in a heavily wooded area overlooking a scenic pond, with a backyard full of roses, in wild profusion. Wild pear, apple and other fruit trees abound in the uncleared area behind their house.

Dr. Emfinger is a demon for rose work, perhaps resurrecting his early ambition to be a gentleman farmer. He and Mrs. Emfinger supply every hospital room when the roses are coming in. Eight months of the year they have enough to provide townspeople's needs for parties, weddings and funerals. They have even provided the roses for weddings as far away as Birmingham—suggesting that anyone thinking about opening a floral shop in Union Springs had better look elsewhere: a flower welfare state already exists there.

No Cause For Alarm

Some physicians have recently become apprehensive that President Reagan may not turn out to be the friend of medicine he appeared a year ago.

Dr. Emfinger, close student of national/political trends, is not alarmed. The essense of his discourse on the subject seems to be: what's good for the country has to be good for medicine. Reagan's attempt to return power and influence to the private sector, along with his pro-competitive philosophy, is an essential step to restoring the economy. Doctors, like other Americans, can only benefit from that.

On specifics, Dr. Emfinger is less sure that some of the simplistic competitive solutions now being kicked around will work. The Medicare voucher theory, for example, is supposed to make services competitive but, Dr. Emfinger says:

"When you start trying to apply some of the other economic principles to the delivery of professional services,—whether medicine, dentistry, architecture, law or whatever—the business principles that may work in purchasing or in government contracts may not work at all.

"You are dealing with something entirely different; you are dealing with people's wishes for a particular individual giving professional service. I'm not so sure that a lot of the programs that have built-in restrictions on choice will ever work. I just don't think people want that. And if they don't want it, it won't work.

"However, I am not concerned about the outcome of the private practice of medicine. I think we are in a much better position now than we have been in many years.

"Competition in the delivery of professional services is going to be faced primarily with two things—quality of service delivered and the personality of the individual delivering it. These are the only two things the public is going to be concerned with.

"Now, I grant you that one of our biggest problems is escalating cost, but that's one of my biggest problems in buying groceries, gasoline and an automobile. Everything is way out of sight.

"I think the voluntary effort has worked to some extent. A lot of the glory PSROs have claimed, as far as effective cost-cutting is concerned, is not the work of PSRO but VE. The same goes for the HSAs.

"Cost consciousness created in the profession and in the hospitals has been a big factor. It irks me that PSRO has taken credit for cost reductions, when I don't think they did it. Any bureaucratic organization or agency has got to claim benefits, money saved, in order to survive. But PSRO is not going to survive and neither are the HSAs."

Block Grants

Asked about block grants, Dr. Emfinger expressed approval of the principle although he did not know details of the Reagan blocks.

"I have been on the city council in Union Springs a total of 20 years, and I like the idea of block grants, rather than designated grants with a lot of strings and bureaucratic red tape and extra expense.

"It will be a different structure, of course, but if we look at the cost of performing a specific service out here, I think block grants will do it a lot cheaper than previous programs, where we had so much bureaucracy extending all the way from the locality where the money was spent to Washington.

"Common sense would dictate that bureaucracy and extra personnel, and extra expense on the state level, is

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600 mg Tablets

One tablet t.i.d.

Please see the following page for a brief summary of prescribing information.

Upjohn

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Motrin® Tablets (ibuprofen, Upjohn)

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other non-steroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin;* use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.
Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea;* epigastric pain;* heartburn;* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness;* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship**

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown**

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship" (PCR)* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Caution: Federal law prohibits dispensing without prescription.

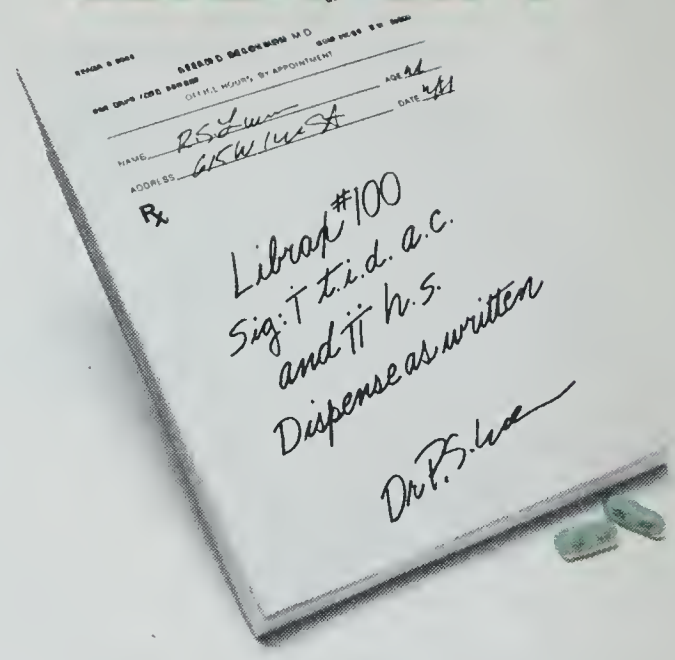
Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-5-S

J-9042-4

July 1981

Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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of Irritable Bowel Syndrome* and Peptic Ulcer*

Librax...the only G.I. medication that provides the action of Librium® (chlordiazepoxide HCl) to relieve the accompanying anxiety found in some patients, plus the action of Quarzan® (clidinium bromide) to reduce colonic spasm and gastric hypersecretion.

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Adjunctive

Librax®

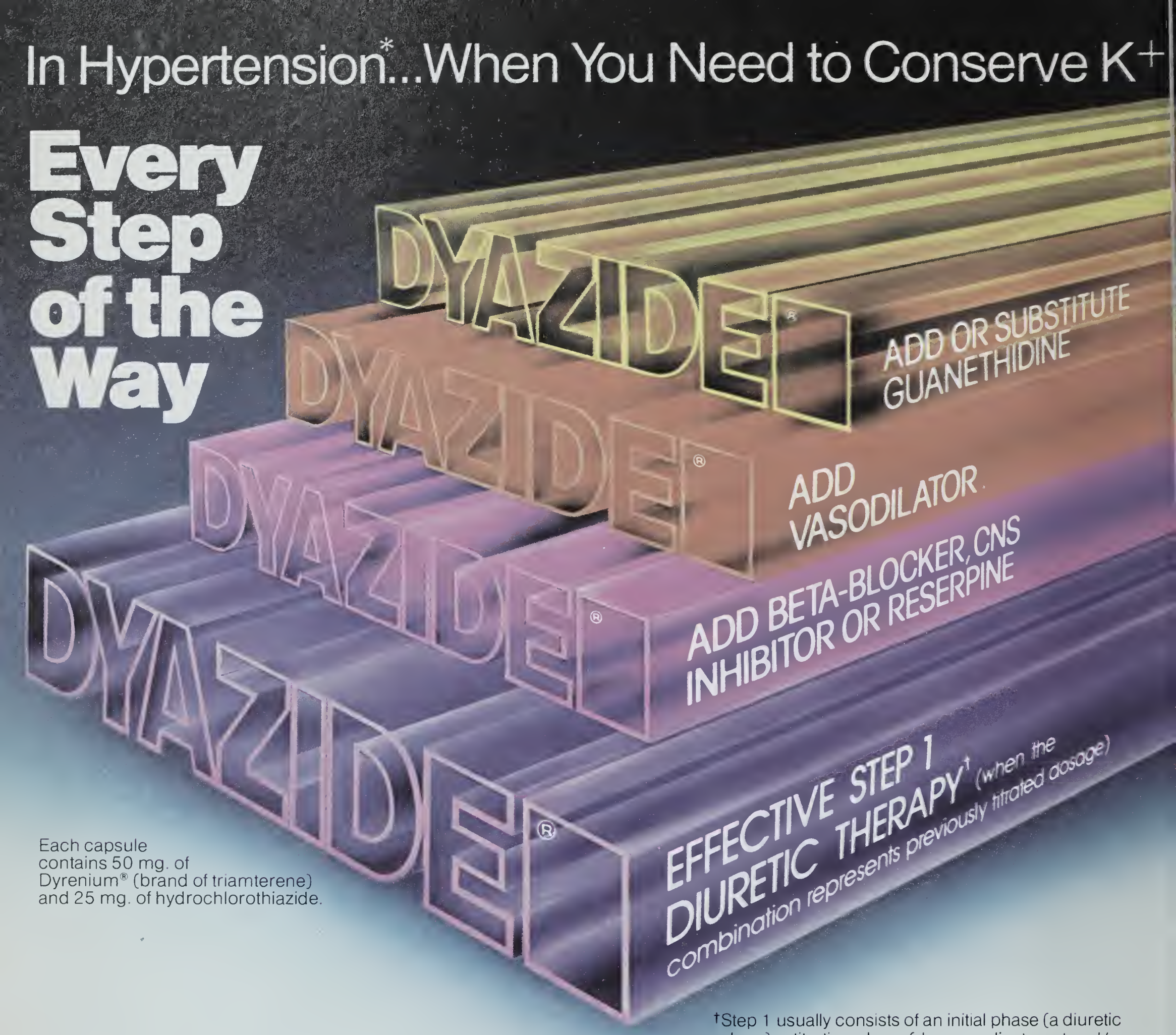
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

*Librax has been evaluated as possibly effective for these indications. Please see summary of prescribing information on facing page.

In Hypertension*...When You Need to Conserve K^+

Every Step of the Way



Each capsule
contains 50 mg. of
Dyrenium® (brand of triamterene)
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†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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not going to be as great as through the block grants. It is not going to as expensive over-all as previously. There should be a lot more real purchasing power in the block grants with X number of dollars than the same X number if Washington had brought it with the strings, restrictions and regs tied to it.

"You know, we've gotten so used to depending on the federal government for grant money, we lose sight of the fact that the money originated with the *people.* When it goes through the bureaucracy, a big chunk of it is lost."

Q: How do you respond to the argument that Alabama and other poorer states get back more than they send to Washington?

Dr. Emfinger: "That is true, but *should* we? I have always maintained that if Union Springs has something we need, let's do it, or not do it, and not depend on somebody else to do it for us. A big change in the economy, as it's being tried by the Administration, is going to hurt some people along the line somewhere. No question about that, but we have got to get back on a sane financial course, even if they *are* hurt.

Q: Pretty soon now, we will begin to hear horror stories as people fall through the new cracks, won't we?"

Dr. Emfinger: "You have horror stories *now*, and it's not always a fault of the system as much as the fault of the individual. Some people won't try. They depend on somebody else to do it.

"Society needs to take care of people who absolutely can't take care of themselves, but at present we are not taking care of these people adequately because we are spreading it too thin and too wide in an attempt to take care of everybody."

"When I came to Union Springs 30 years ago, this was the 10th poorest county in the United States. I know quite a bit about who cannot buy groceries or pay for medical care—and then are those who will not try to. We have third and fourth generation welfare people here now, the only economy they know. When I first came here, I did a tremendous amount of charity work—probably 25% of my practice.

"I knew it was a poor community and I'd rather do charity again than have the programs we have. I still do a lot, including that for people on Medicare and Medicaid, semi-charity and total charity rather fool with Medicaid. I participate in Medicare and Medicaid, but there are times when I would rather do it on a charity basis.

"In cases where I know people absolutely cannot afford it, I don't mind charity. But you've got a lot of people on Medicaid/Medicare who can afford it. They come to an office in a car that's much newer than the one I have. And when I see them spending their money and sitting there at my desk, smoking two packs of cigarettes a day, and listen to them say they can't afford to buy medicine or pay for a doctor bill, I say there is something wrong with their priorities."

A Return To Family?

Q: There will obviously be a cutback on a lot of programs for the elderly. Do you see that as forcing a return to family responsibility?

Dr. Emfinger: "Yes, and I think that is absolutely the thing that ought to be done. We used to have a Relative Responsibility Law in Alabama. It was repealed many years ago, and I think we ought to go back to it."

Q: In your judgment, do some of these programs, even Medicaid and Medicare to some extent, pay for nursing homes as a way of getting rid of people and relieving children of what used to be a family responsibility? If that is so, is it not also true that these subsidies are actually supporting the children rather than the parents?

Dr. Emfinger. "No question about it, although there are some old folks who have no family, no one to take care of them. Society should certainly take care of these. If there are no federal funds, or welfare checks, the community ought to help.

"There are cases where the farm family decides to retire and gives the farm to the children. They then become paupers to qualify for Medicaid. There are laws to prevent this, but they have not been effective. A lot of these people should be taken care of at home."

Egyptian History Next

After reading everything there is to read on English and American history, Dr. Emfinger is interested in taking up Egyptian history:

"I got interested in that reading a novel based on Egyptian history. I never knew much about it.

"European history is a maze, so hard to keep in order and understand as a whole, while English history is much easier. The American Civil War period is one of the most fascinating pieces of history in any country."

On assorted subjects:

Dr. Emfinger is opposed, as is well known, to mandatory CME, in the belief that it is really impossible to force doctors to learn if they are not inclined; that the requirement makes doctors "intellectually dishonest"; that many of the credits granted have nothing really to do with a particular physician's improved patient care ("The best way to get doctors to keep up is to get a bright new doctor in the community. Then the others *will* keep up.")

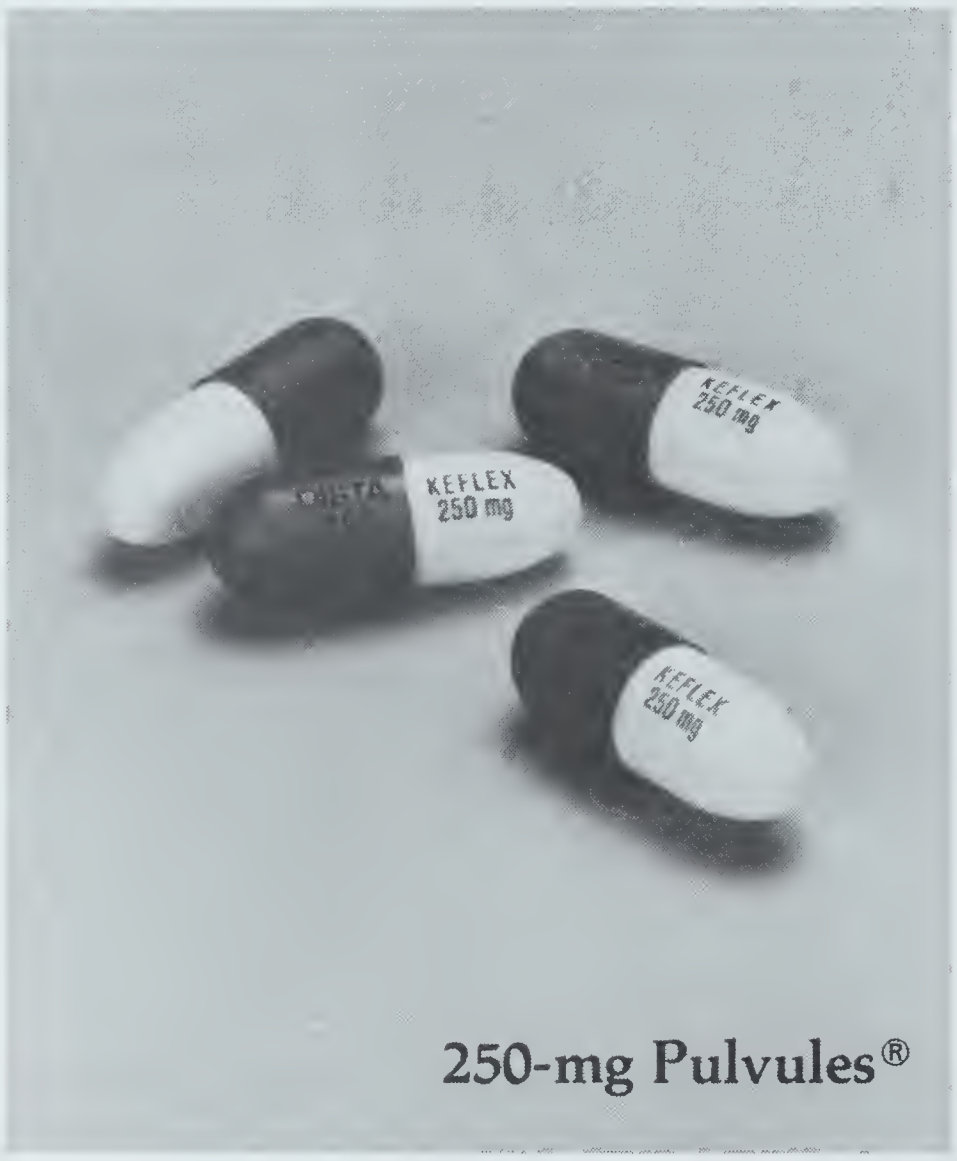
He favors a return to rotating internships because, he says, the extra year of rotating training is needed and provides more time for a more informed choice of specialty.

And he would still like that good history of England before Alfred The Great in the 9th Century.

Dr. and Mrs. Emfinger have two boys and two girls, with only one of the boys still at home—"transiently at home," Dr. Emfinger says, "sometimes he is in school and sometimes he's working."

If you need any Christmas roses, give him a call. Sometimes he has a supply as late as Christmas week.

easy to take



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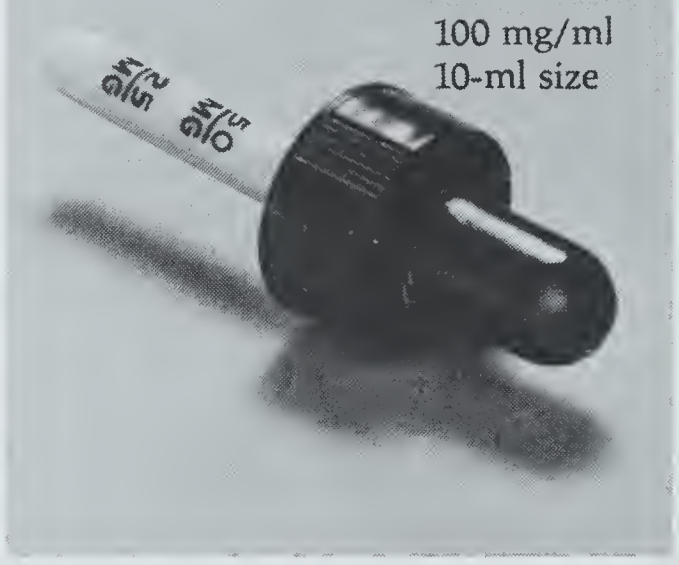

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THORNS IN OUR GARLAND

S. D. Palmer, M. D.

In thinking upon the notable accomplishments in pediatrics during the half century past, I was awed by our success. The increased span of life has to be ascribed in significant measure to the conquest of childhood diseases.

Whereas at the turn of the century, 100 out of every thousand babies never reached their first birthdays, now the figure is 13. In our own state, 3,439 children under five years of age died in 1933, in 1979, 747. If the 1900 death rate for tuberculosis, diarrhea, diphtheria and polio had persisted, 840,000 Americans would have died thus in 1977.

Smallpox is no more. The disease whose victims numbered millions has been eradicated, we believe, from the face of the earth. With it, too, the tragic deaths from vaccinia, casualties of the combat. Infantile diarrhea, a former scourge, is now usually an annoyance, a cause of morbidity but infrequent death. (Only 9 in 1979, and in 1933, *549*.) Tuberculosis is uncommon to the dangerous point of complacency, as Marilyn Crumpton in Houston County can properly warn us.

The closing chapters of the saga of the conquest of poliomyelitis are being written as the ink of the first chapters is still wet. Not many years, it seems, have passed since big Leo Bashinsky and Jerry Weaver and others were spending long hours in the wards, with polio patients. Big hearted Bill Daniel, who had had polio himself while in medical school, and who considered it as a personal affront, waged exhaustive battle against the disease in the acute care ward of St. Jude's, Montgomery. History records that his colleagues had to extricate him from his patients, the hot packs and the respirators with a peavy pole. We *can* finish our task with polio; the means are there.

Fading into the shadows, the infrequent cases of diphtheria, typhoid fever, pertussis, tetanus, and rabies are medical curiosities, awareness of which distinguishes the alert physician. In 1933, 180 children under five died of whooping cough in Alabama; in 1969, none. Only a few days ago, we were in a discussion with a learned otorhinolaryngologist regarding the possibility of pertussis in a mutual patient. His erudition was cloyed by the admission that he had never seen a case nor heard a whoop. Few latter-day pediatricians have seen diphtheria, tuberculous meningitis, congenital syphilis (101 children died of it in 1933!) or typhoid fever. What a blessing!

Workmanship and Accountability

In the not-so-many years since Wallace Clyde and John Burrett set up their clinic for children with congenital heart disease, a happy melding of personal skill, perseverance, engineering and electronic finesse, and dedication of some great people has wrought a miracle, a whole bunch of miracles. Jacques Barzun's admonition that the public expects of a profession two things—workmanship and accountability—is nowhere more evident than in pediatric cardiology and cardiovascular surgery.

The beloved Bob Parker has promoted the cause of mental health throughout his career. In the denouement of his magnificant life, he can with some pleasure reflect

upon progress in that area. (But *vide infra!*) The preservation, and the recognition of the *need* for preservation, of humanness in the practice of our profession is itself an accomplishment of the half century, Jacques Baumhauer pointed out. In an arena beset with magic gadgets, with computers and computer-operators and computer-operator-watchers, pediatrics, more than most specialties, has succeeded in maintaining its humanity. Hughes Kennedy, Jr.—now there's a gentleman for you! In his chock-full life, the cause of school health, preventive maintenance of kids, won great devotion.

There are garlands all over the place. Finding garlands is not much of a problem. Establishing any sort of hierarchy of the garlands is as difficult, perhaps, as it is pointless. The status of pediatrics as a boarded specialty just about spans the fifty years and Brobdingnabbian strides have carried our profession far.

But there are thorns in those garlands. Tares in our wheat. Flies in our ointment.

We have finally nearly stopped that abusive misnomer of equating "incurable" with "hopeless." But although we can cure a lot of kids with acute leukemia, we haven't yet mastered the knowledge of what turns the T or the B or the pre-B cell to suicidal destructiveness.

In spite of wholesale accumulation of numbers (those frigid digits), of sicklers and sickle-traits, and a better biochemical comprehension of sickling, our *treatment* of kids with sickle cell anemia is still at the starting post.

The perversities of neuroblastoma are still perverse. (Who will reverse perversity?) Why the difference between Stage IV and IV-S? In advanced disease, III and IV, the incidence of 2-year disease-free interval seems to be no better than in the days before chemotherapy.

With the succeeding (if not quite success) story of the treatment of Hodgkin's disease, is the spectre of serious consequences of treatment, early and late. Radiation effects, sepsis, and second malignancies elude conquest.

Many Unknowns

Along with the welter of hemoglobinopathies, sparked by the definition of Hemoglobin S, comes a host of other genetic diseases. But in some 3000 single-gene diseases, the specific biochemical defect is known in only 100. The missing or altered biochemical manifestation is unknown. Earlier and more precise identification, an ultimate remedy, perhaps by genetic engineering, enhanced counselling of parents at risk, all await facilitation by the biochemist.

In medicine, as woven throughout life's tapestry, "knowledge comes, but wisdom lingers." We can generate zygotes *in vitro*–but we don't know what to do with them. With example set by large-animal husbandry, we can artificially inseminate surrogate mothers—yet we don't know whose baby it will be. With the help of the courts and imprudent jurisprudence, we no longer know when we die. The beginnings and the endings of life no more are simple and mystical. They have been scrutinized and abused. As Wordsworth complained about someone's "peeping and botanizing upon his mother's grave," these elements of the life process seem, perhaps, not quite to be designed for destructive analysis.

Juvenile diabetes mellitus, in spite of all our efforts, is no success story. Type I diabetes—JDM—of 35 years' duration is associated with a 50% mortality. Of those who are still living after 35 years of diabetes, 40% will have seriously impaired vision. A large number of adolescent diabetics commit suicide.

A black newborn is still nearly twice as likely to die in infancy as a white baby. The gap between blacks and whites in infant mortality is not narrowing, as they both decrease at the same rate. The disparity in infant mortality rates by race is accentuated in the post-neonatal period, at a time more susceptible to socioeconomic and environmental influences. Since a significant factor in infant mortality is low birth weight, one targeted area should be black low-birth-weight infants and the women who bear them.

One thorn in our garland is a pathetic apathy to the public health. Despite the major contributions to the public health by a few pediatricians, we acknowedge that they are usually by somebody else; not you or me. Alabama has had two cases of measles in over a year now, largely the consequence of our cheerless compliance with the blue slips for school: "Imm. 50". Polio is reduced to an unexciting, surreptitious marauder, because we, with a million others, participated in Sabin Oral Sundays, et al. But the health of the public needs continuing participation and support by the group most dedicated to the health of tomorrow's people. We are apathetic.

"Tomorrow's people." That's something else. Through our efforts, children whose diseases would have taken their lives, and promptly, are surviving. Sometimes for very long years. As we have taken these children from the Fates, have we also, as a people, accepted the responsibility for what we have done? Though the incidence of cerebral palsy has changed little, perhaps, the longevity of these children has increased considerably. But they're not *well,* and medicine has saved them from an earlier death only to submit them to a protracted, uncomfortable life. Are we involved in socioeconomic planning for these children? More generally, as a profession are we concerning ourselves adequately with consideration of the quality of life for the children who now may survive yesterday's Nemesis? The children with cystic fibrosis—with Trisomy 21—with JDM—with meningomyelocele—with any chronic disease, tend to be loners, to be frustrated, perhaps a little angry. How can we assure their happiness?

That wonderful expression, "horror autotoxicus"—the body has an aversion for poisoning itself—was

for Knotts in the night

Prescribe new formula

Quinamm*

(quinine sulfate tablets)

each tablet contains quinine sulfate 260 mg

Specific therapy for painful night leg cramps

Merrell Dow

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Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

Quinamm™

(quinine sulfate tablets)

CAUTION: Federal law prohibits dispensing without prescription

BRIEF SUMMARY

INDICATIONS AND USAGE

For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS

Quinamm may cause fetal harm when administered to a pregnant woman. Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g) for attempted abortion. In about half of these reports the malformation was deafness related to auditory nerve hypoplasia. Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes. In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys. Quinamm is contraindicated in women who are or may become pregnant. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency.

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use. Recovery usually occurs following withdrawal of the medication and appropriate therapy.

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever.

WARNINGS

Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism. Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision; however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin.

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine. Quinamm should be stopped immediately if evidence of hemolysis appears.

If symptoms occur, drug should be discontinued and supportive measures instituted. In case of overdosage, see OVERDOSAGE section of prescribing information.

PRECAUTIONS

General

Quinamm should be discontinued if there is any evidence of hypersensitivity. (See CONTRAINDICATIONS.) Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken. Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form. Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy.

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine. (See Drug Interactions.)

Drug Interactions

Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration. Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly.

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

The effects of neuromuscular blocking agents (particularly pancuronium, succinylcholine, and tubocurarine) may be potentiated with quinine, and result in respiratory difficulties.

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity.

Drug Laboratory Interactions

Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used.

Carcinogenesis, Mutagenesis, Impairment of Fertility

A study of quinine sulfate administered in drinking water (0.1%) to rats for periods up to 20 months showed no evidence of neoplastic changes.

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test. Intraperitoneal injections (0.5 mM kg.) were given twice, 24 hours apart. Direct *Salmonella typhimurium* tests were negative, when mammalian liver hemogenate was added, positive results were found.

No information relating to the effect of quinine upon fertility in animal or in man has been found.

Pregnancy

Category X. See CONTRAINDICATIONS.

Nonteratogenic Effects

Because quinine crosses the placenta in humans, the potential for fetal effects is present. Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown. Quinine in toxic amounts has been associated with abortion. Whether this action is always due to direct effect on the uterus is questionable.

Nursing Mothers

Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts).

ADVERSE REACTIONS

The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage. (Individual or multiple symptoms may represent cinchonism or hypersensitivity.)

Hematologic: acute hemolysis, thrombocytopenic purpura, agranulocytosis, hypoprothrombinemia.

CNS: visual disturbances, including blurred vision with scotomata, photophobia, diplopia, diminished visual fields, and disturbed color vision, tinnitus, deafness, and vertigo, headache, nausea, vomiting, fever, apprehension, restlessness, confusion, and syncope.

Dermatologic/allergic: cutaneous rashes (urticarial, the most frequent type of allergic reaction, papular, or scarlatinal), pruritus, flushing of the skin, sweating, occasional edema of the face.

Respiratory: asthmatic symptoms.

Cardiovascular: anginal symptoms.

Gastrointestinal: nausea and vomiting (may be CNS-related), epigastric pain.

DRUG ABUSE AND DEPENDENCE

Tolerance, abuse, or dependence with Quinamm has not been reported.

OVERDOSAGE

See prescribing information for a discussion on symptoms and treatment of overdose.

DOSAGE AND ADMINISTRATION

1 tablet upon retiring. If needed, 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring.

After several consecutive nights in which recumbency leg cramps do not occur, Quinamm may be discontinued in order to determine whether continued therapy is needed.

Product Information as of October, 1980

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works just as well in their homes.

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- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

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never totally true. It was neat to learn in medical school, but it didn't always work. And it still doesn't. Just last week a friend of mine was told that she has lupus. We don't know what to tell her about *why*. Rheumatoid arthritis, scleroderma, chronic active hepatitis, that fascinating set of diseases, is more treatable, even controllable, but the "etiology is obscure," to use one of our playful synonyms for ignorance.

Incomplete Knowledge

"The child is father to the man." Without destroying autonomy or discouraging spontaneity, how can we by early control of environment (internal and external) improve the health of the next generation? Salt and hypertension—that's coming on. Diet and atherosclerosis? Family structure and the development of Type A behavior? Obesity? Peptic ulcer? Smoking and lung cancer? By some it is thought that 14% of premature births are related to maternal smoking. Knowledge of the assurance of adult health by childhood guidelines is incomplete, and our participation in these efforts is still more so.

A thorn in our garland is the determination of the dysmature fetus and timing of its delivery. How can we establish prematurity, intra-uterine growth retardation, postmaturity, in a safe way and, safely, intervene?

Early on, it used to take 5 ml. of blood for a bilirubin determination on a newborn. There was a lot more "physiologic jaundice" in those days! Those patients who were unfortunate enough to have marked jaundice and accessible femoral veins were likely to develop anemia on an other-than-hemolytic basis. The establishment of a safe level of bilirubin is being restudied. The magic "20" of Dr. Hsia and others was frequently replaced by other numbers, it seems, under various sets of circumstances. And now we've lost the key to the puzzle and have to reassess.

I reluctantly acknowledged, some years back, that God is smarter than all men and most women. Put together. Now we're involved in maternal-infant bonding, and breastfeeding, and delivery of newborn care in a humane, loving basis. But we haven't really gotten in control of the problem of subsequent child abuse of the sick and tiny newborns.

Hostile Households

Child abuse in *all* its ugly manifestations. Lots yet to do with that, commencing with an attitude of caring, for the parents as well as the children, with a grim resentment of a society which would germinate the hostile households from which come many cases of abuse. We've progressed, fairly well, from the days not long past in which the Law would instantly and permanently and righteously snatch an abused child from its parents—and not really concern itself with the why, with the psychologic framework within which the child was battered.

Boy, that's a whole new area: the interrelationship of the bio-psycho-social aspects of disease. "New"—like the beginnings of Man. New like this year and tomorrow. We pay but lipservice to the need for outgrowing the dualistic approach to disease. We learn little and practice less of this discipline.

Death by suicide is *increasing* among adolescents. It is now the third leading cause of death, led by accidents and homicide. Daily, in our country, 14 teenagers kill themselves. Whose fault is that? Who will remedy? The high rate of *unsuccessful* suicide attempts in adolescents, many times that of adults, bespeaks a crying for help. Are we really helping? Are we part of the problem? Are we trying not to become involved?

Gliomas—they still kill. Griff considers this a prime problem, a long thorn in our garland. We operate, irradiate, treat with drugs, and yet the children die. Management of the child born with a neural tube defect is far from satisfying.

Preventing Defects

What about prevention? The time for this is shifting to the left—how to prevent meningomyelocele and hydrocephalus? It's not enough to appraise the likelihood of the fetus's already having a neural tube defect by alpha fetoprotein assay; how can we prevent it altogether?

Neonatal nutrition, nutrition in pediatrics generally. The non-physician enthusiasts are more loquacious, if not more learned, than we. Only a few of us are really knowledgeable about the nutritive needs of our patients, and even fewer can speak to global needs and our involvement. While quixotically tilting at the windmills of multinational infant formula corporations, we knowingly slight the concurrent issues of maternal malnutrition, polluted water, societally abused women, global misery. The platitudes of breastfeeding cannot solve these very real issues.

A few in our midst are distinguished among the peers by their exuberant selflessness. Benjamin Clark is one; "Lu", Gertrude Luther, is another. A thorn *must* be that we are not *all* so reputed.

A thorn in our garland, indeed, is the cost of provision of medical care, in ever-increasing dimensions, to the patient. (The "consumer", maybe; the "client", never!) The cost of newborn care in an NICU is appalling.' The impact of major illness—cerebral palsy, SLE, leukemia, sickle cell anemia—is almost inestimable.

The Elusive Harigan

Garlands are plentiful in the retrospection of a half century of pediatrics, but thorns not a few. As Tennyson's Ulysses said of his waning manhood, "Though much is taken, much abides." Though conquests accomplished have stripped some of the most perverse of medical challenges from the Unknown, much is left. The horizon is as far as ever. Its pursuit is a dedication and a ministry. What more can we ask of the Creator?

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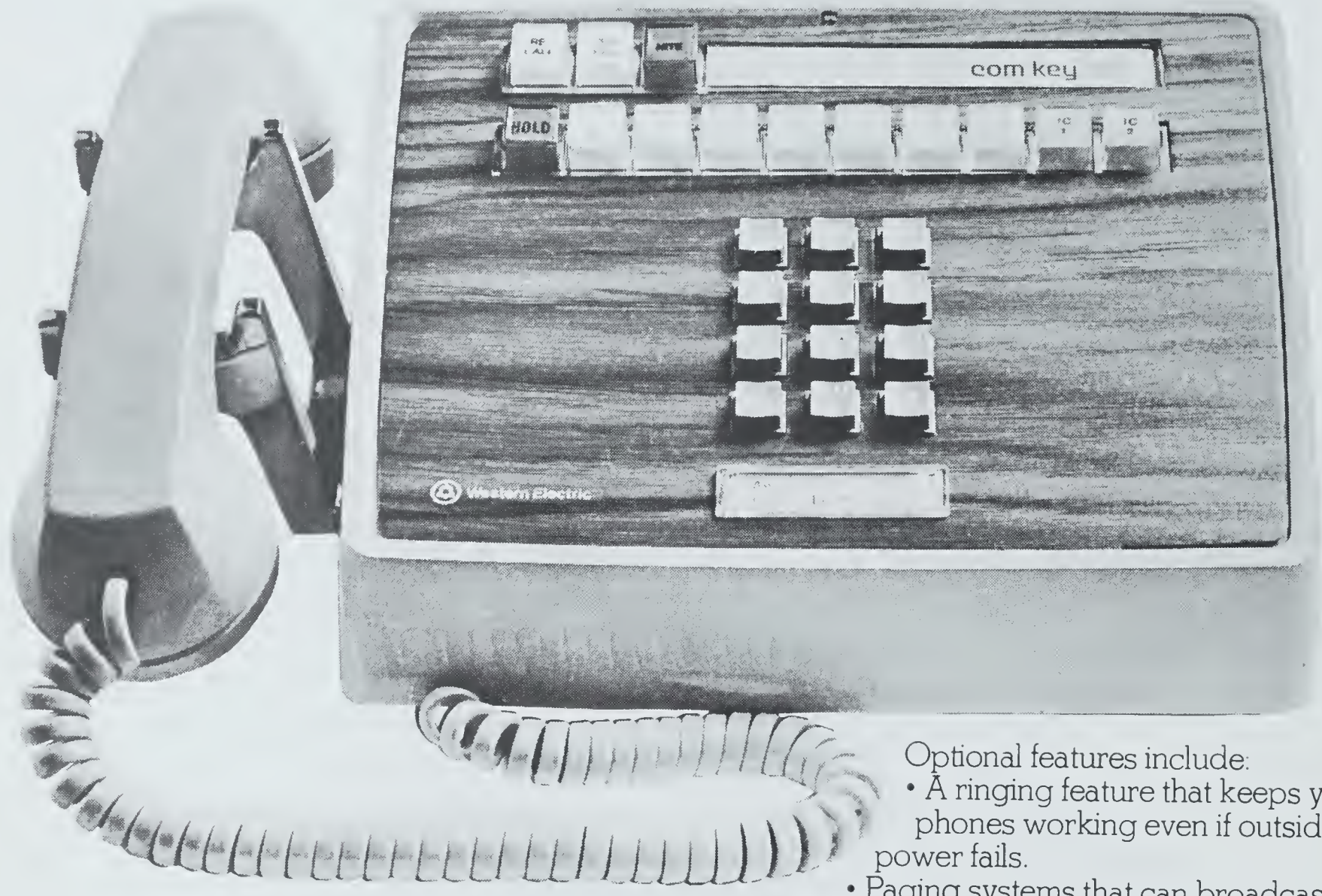

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A Safe and Cost Effective Method of Colon Resection

by

Z. B. Barnes, M. D.

According To Eiseman[1] the most common complications following colon resection are urinary infection (14%), wound infection (12%), anastomotic leak (17%) and thromboembolism (10.4%). He also notes an operative mortality of 5-15%. Welch and Donaldson[2] cite a surgical complication rate of 33%, postoperative wound infection in 5.7% with intra-abdominal abcess or peritonitis in 2.4%.

I have reviewed 38 consecutive patients who underwent colon resection during the past 5 years in order to determine the complications and mortality rate of colon resection in my practice. All patients underwent surgery for carcinoma or diverticulitis, and most were electively operated following colon preparation. The ages ranged from 24 to 81 and average ages were in the sixth and seventh decades. Resection of the disease with end to end anastomosis was performed in most all cases. When necessary to protect an anastomosis of the left side of the colon, a right transverse loop colostomy was done.

Pre-operative preparation consisted of a liquid diet 24 hours prior to surgery, oral antibiotics on the P.M. prior to surgery, and laxative and enemas as needed to clean the colon. The oral antibiotics used were erythromycin base and neomycin given in dosages of 1.0 gram each at 2:00 P.M. and 10:00 P.M. on the day prior to surgery. In addition, most all patients received a cephalosporin (cefazolin or cephamandol) in dosage of 1.0 gram given intramuscular on call to surgery, or intravenous as the incision was being made in the operating room. Post-operative care included restriction of all oral intake until the passage of flatus or feces. This interval usually was three to four days during which a naso-gastric tube was also used. Intravenous fluid and electrolytes were given in proper volume until oral intake was sufficient. All patients had a bladder catheter inserted after anesthesia was induced in the operating room, and the catheter was not removed until the third or fourth post-operative day. Post-operative antibiotic therapy was limited to two intravenous doses of cephalosporin given approximately four and eight hours post-operative.

All laparotomy incisions were midline. All anastomoses were hand sewn using a two layer posterior suture line consisting of interrupted sero-muscular sutures of 3-0 silk and a running mucosal suture of 3-0 vicryl or catgut, and a one layer anterior suture line of 3-0 sero-muscular silk sutures. Prior to abdominal closure, saline irrigation of the peritoneal cavity was done as needed to remove blood. No intraperitoneal antibiotics were used. Wound closure consisted of one layer interrupted suture line of midline fascia and peritoneum using far and near sutures of "O" prolene. In all cases the subcutaneous fat and skin were not closed. The subcutaneous space was not separated by any packing material. Wounds were then covered with Adaptek and sterile gauze, and dressings changed personally by the operator only as necessary during the post-operative period. On approximately the fifth post-operative day, skin approximation was accomplished by the use of tape, when needed.

All patients were ambulated within 24 hours following surgery and progressively to tolerance thereafter. When oral intake was begun, this consisted of clear liquids for 24 hours followed by diet as tolerated. No laxatives or post-operative enemas were used. No antibiotics were given post-operative just because a bladder catheter had been used, and bladder catheters were not irrigated in any case.

In no case was parenteral alimentation needed or used and in no case was tube feeding given. Gastrostomy tube insertion was never used; and no feeding jejunostomy were ever needed or done. No effort was made to employ any special diet either before or after surgery. No intravenous vitamin preparations, amino acids, or solutions other than a glucose-electrolyte solution were given post-operative.

Any granulation tissue at the site of the abdominal wound was touched with a silver nitrate stick every few days until complete skin to skin healing. Patients were allowed to bathe after all would tape had been removed. After leaving the hospital, all patients were seen in the office personally by the operator every week until recovery.

No special prophylactic measures were taken to prevent phlebothrombosis, so that no patient received heparin or dextran or aspirin.

Colostomy closure was in all cases done no sooner than six weeks following colon resection, and in each case was preceded by an out-patient x-ray of the recto-sigmoid using gastrograffin. Colostomy closure was performed under general anesthesia. Technique consisted of dissection of the colostomy from skin, fat, muscle, and fascia by incising and dissecting around stoma and colon, and closure of the colon with a one layer suture line 3-0 silk for sero-muscular coat. The surgical wound, following colostomy closure, was treated in an identical manner as in colon resection and pre and post-operative antibiotics were also given in same dosage. The use of a bladder catheter was generally never required in the management of colostomy closure, and neither was nasogastric intubation. These patients, as a rule were given nothing by mouth post-operative until passage of flatus or feces (usually about 48 hours) and during this time fluid intake was by the intravenous route. There was no operative mortality or wound infection in this group of patients.

Review of 38 cases of colon resection shows no mortality rate, no wound infection, no clinical urinary infections, no anastomosis leaks or fistulae, no intraabdominal abcesses, and no clinically detectable phlebothrombosis or pulmonary embolae. The average hospital stay in this group of patients was 9.3 days post-operative. I believe that the absence of wound infection is due to the combined use of a good bowel preparation, a blood level of cephalosporin during surgery and for eight to twelve hours thereafter, and not suturing the skin and fat of the operative wound.

The techniques as outlined, pioneered and developed by others, when properly used in combination yields the most risk-free and cost effective results of colon resection.

38 CASES OF COLON RESECTION

Location of Lesion	Rectosigmoid	27	Type of Lesion	Carcinoma	27
	Descending colon	3		Diverticulitis	11
	Transverse colon	3			
	Right Colon	7			

Abcess, perforation or fistula found at laparotomy	8
Ostomies	9
Incidental cholecystectomies for gallstones	4
Operative mortality	0
Wound infections	0

REFERENCES

1. Eiseman, Ben, M.D.—"Prognosis of Surgical Diseases", N. B. Saunders Co., 1980, pp. 298-99.
2. Welch, John P., M.D. and Donaldson, Gordan A., M.D.—*The American Journal of Surgery* 127: 258-266.

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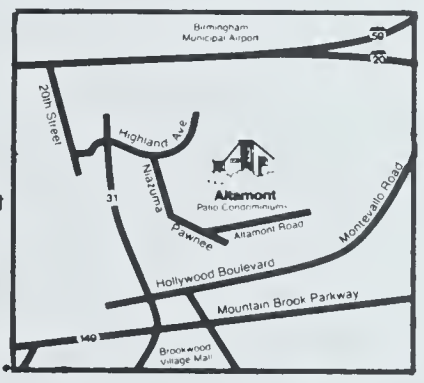

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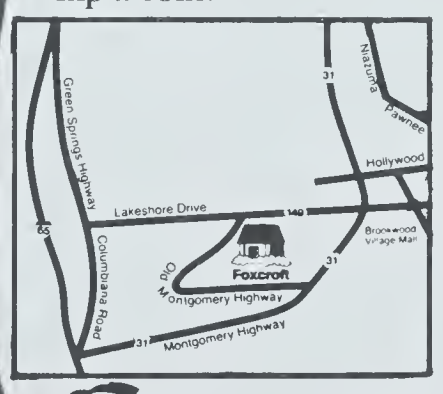

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Lysenkoism At UAB

Roy Curtiss, III, Ph.D., had just arrived at UAB's Microbiology Department some years ago when a prankster inserted in a UAB bulletin the notice that Trofim D. Lysenko would lecture on "A Critical View of Darwinism" in one of the Medical Center's lecture halls. At the appointed time, many people showed up, although Prof. Lysenko did not.

His name, and the derivative Lysenkoism, is synonymous with the politicalization of science by the state. In 1937, Lysenko was appointed head of the Soviet Institute of Genetics. Rejecting the conventional wisdom of hereditary genetics, he solemnly pronounced most characteristics were inculcated by the environment. In Stalinist Russia, this fit the new view of the ideal state perfectly: the state produced character and social worth, not heredity. All Soviet scientists who resisted the nonsense were banished to Siberia or otherwise ostracized and humiliated.

In 1976-77, Senator Kennedy and HEW Secretary Califano moved to ban Recombinant DNA research, in which Dr. Curtiss is an acknowledged world leader. U. S. scientists cried "Lysenkoism." Shortly thereafter, UAB conferred on Dr. Curtiss an endowed chair in microbiology. Since funds for the chair were not immediately available, his laboratory staff presented him their own chair, shown here.

There is at least a presumption that the author of the earlier lecture and this chair are the same, but Dr. Curtiss denies all knowledge.

William H. McDonald

LYSENKO CHAIR
IN MICROBIOLOGY

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CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitra activity than ather drugs in the ampicillin class and its use shauld be canfined ta these indicatians: Treatment af the fallawing infectians:
RESPIRATORY TRACT
Tansillitis and pharyngitis caused by Graup A beta-hemalytic streptacacci
Branchitis and pneumania caused by *S.* pneumaniae (farmerly *D.* pneumaniae)
Otitis media caused by *S.* pneumaniae (farmerly *D.* pneumaniae) and *H. influenzae*
Acute exacerbatian af chranic branchitis caused by *H. influenzae**
*Thaugh clinical impravement has been shawn, bacterialogic cures cannat be expected in all patients with chranic respiratary disease due ta *H. influenzae.*
SKIN AND SKIN STRUCTURES (integumentary) infectians caused by Graup A beta-hemalytic streptacacci and staphylacacci, nanpenicillinase praducers.
URINARY TRACT INFECTIONS caused by *E. cali* and *P. mirabilis.* (This drug should nat be used in any *E. cali* and *P. mirabilis* infectians ather than urinary tract.)
NOTE: Perfarm cultures and susceptibility tests initially and during treatment ta manitar effectiveness af therapy and susceptibility af bacteria. Therapy may be instituted priar ta results af sensitivity testing.
Contraindications Cantraindicated in individuals with histary af an allergic reactian ta penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Pralanged use af antibiatics may pramate avergrawth af nansusceptible arganisms. If superinfectian accurs, take appropriate measures.
PREGNANCY: Pregnancy Categary B. Repraductian studies perfarmed in mice and rats at dases up ta 10 times the human dase revealed na evidence af impaired fertility ar harm ta the fetus due ta cyclacillin. There are, however, na adequate and well-cantralled studies in pregnant wamen. Because animal repraductian studies are nat always predictive af human respanse, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is nat knawn whether this drug is excreted in human milk. Because many drugs are, exercise cautian when cyclacillin is given ta a nursing waman.
Adverse Reactions Oral cyclacillin is generally well talerated. As with ather penicillins, untaward sensitivity reactians are likely, particularly in thase wha previausly demanstrated penicillin hypersensitivity ar with histary af allergy, asthma, hay fever, ar urticaria. Adverse reactians reparted with cyclacillin: diarrhea (in appraximately 1 aut af 20 patients treated), nausea and vamiting (in appraximately 1 in 50), and skin rash (in appraximately 1 in 60). Isalated instances af headache, dizziness, abdaminal pain, vaginitis, and urticaria have been reparted. (See WARNINGS) Other less frequent adverse reactians which may accur and are reparted with ather penicillins are anemia, thrambacytapenia, thrambacytapenic purpura, leukapenia, neutrapenia and easinaphilia. These reactians are usually reversible an discantinuatian af therapy.
As with ather semisynthetic penicillins, SGOT elevatians have been reparted.
As with antibiatic therapy generally, cantinue treatment at least 48 ta 72 haurs after patient becames asymptamatic ar until bacterial eradicatian is evidenced. In Graup A beta-hemalytic streptacaccal infectians, at least 10 days' treatment is recammended ta guard against risk af rheumatic fever or glamerulanephritis. In chranic urinary tract infectian, frequent bacterialagic and clinical appraisal is necessary during therapy and passibly far several manths after. Persistent infectian may require treatment far several weeks.
Cyclacillin is nat indicated in children under 2 manths af age.
Patients with Renal Failure Cyclacillin may be safely administered ta patients with reduced renal functian. Due ta pralanged serum half-life, patients with variaus degrees af renal impairment may require change in dasage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced dases)

INFECTION	ADULTS	CHILDREN*
Respiratary Tract Tansillitis & Pharyngitis	250 mg q.i.d.	bady weight < 20 kg (44 lbs) 125 mg q.i.d. bady weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumania		
Mild ar Maderate Infectians	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chranic Infectians	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg ta 500 mg q.i.d.†	50 ta 100 mg/kg/day†
Skin & Skin Structures	250 mg ta 500 mg q.i.d.†	50 ta 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dasoge shauld not result in a dose higher thon that far adults.
†depending on severity

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compared to 32 minutes for ampicillin.*

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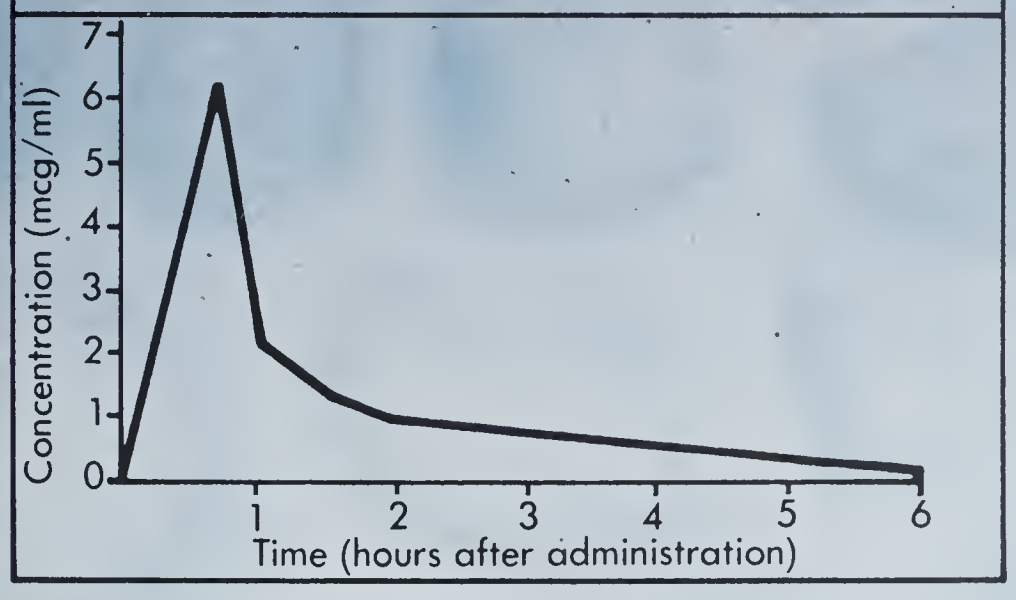

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- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T^{a} ½ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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NEW NAME

Bellevue: Form Follows Function

by Gerald Weissmann, M. D.
In Hospital Practice

These days, most of the great teaching hospitals of the world resemble urban sites in search of an archeologist. Perhaps their pavilions, wings, annexes, and towers were first planned in conformance with one central design. But, thanks to a donor here, a social need there, an architect's vanity, or a committee's decree, these institutions astonish the modern visitor with a display of architectural styles as varied in structure as in function. Like the Necker and Sanit Antoine hospitals in Paris, Guy's and the former Addenbrook's of England, Hopkins and the Brighams of our own country, Bellevue Hospital of New York sends structural signals of history and confusion, change and accommodation.

The main building, conceived in the sixties and finally occupied in 1975 (Katz, Waisman, Weber, Stauss, Blumenkranz, and Bernhard, and Pomerantz & Breines), is a square block of pebbled concrete panels and glass, 25 stories high. This fortresslike structure by the East River is a municipal version of its more graceful precursors in the American Corporate Empire style of lower Park Avenue. Indeed, its glass-encased reception lobby recalls the spacious dining room of the Four Seasons restaurant in Mies van der Rohe's Seagram building. With what appropriate irony! The homeless alcoholics of Bellevue frequently sleep off Seagram's "Four Roses" on the vinyl banquettes that stud this toned-down version of Mies's agora of the three-martini lunch.

No solitary megalith, our citadel of healing is connected by a series of arbitrary tunnels, walkways, and corridors to vestiges of earlier orders of architecture. One or two of the red-brick and green-copper pavilions of McKim, Mead, and White's old Bellevue (1908-1916) still remain amongst the rubble of their cohort. Their abandoned loggias and decorated balconies recall the epoch when fresh air was still available and considered therapeutic. A large administration building (1939, also McKim, Mead, and White) courageously blends elements of a Palladian facade with the muscular machine forms of the depression.

On top of this edifice are corrugated metal superstructures that shimmer in the winter sun. These boxlike affairs were used as temporary operating rooms in the fifties. *O tempera, o moire!* In the days when house officers were truly "interns" and had to reside in hospital, this building housed their sleeping quarters and scruffy lounges where poker games began at midnight. In the basement was the doctors' dining room, where municipal waitresses served white dinners (filet of sole, cauliflower, macaroni) on white plates over white tablecloths to men in white (there were very few women).

The old C and D building of the chest service, center for many years of tuberculosis treatment and research, also exposes its residual balconies to the Manhattan soot. It is of a piece and period (1939, York and Sawyer) as the administration tower. Its former use now superseded by streptomycin and isoniazid, the "chest building" houses a large security department, some squalid research warrens, and the prison ward. In corridors where once the phthisic wandered with collapsed lungs, wearing small cotton masks, cell biologists and immunologists now compete for lebensraum with manacled transfers from Riker's Island and bulky correction officers. The facade is an acceptable mix of neo-Georgian detail with (what foresight!) the bulky elevations of Alcatraz.

Another survivor is the psychiatric building (1937, Thompson, Holmes, and Converse). This red-brick and granite structure appears to have been based upon a misapprehension of the Villa Medici. Its windows, barred to foil the suicidal, contrast with cinquecento porticoes, Michelangelesque stairways, carved pediments, and fluted cornices—visual tributes to the rational use of the higher faculties. Psycho has played host to the inspired and the dangerous: from Norman Mailer to the East-Side Slasher, from Malcolm Lowry to the Son of Sam.

These major buildings house the 1,200 beds that have made Bellevue (founded as an almshouse in 1736) not only the oldest city hospital in our country, but also its largest teaching institution. And perhaps the first fact taught to student or visitor is that there is no logical way to enter it. Unless brought directly by ambulance to the emergency entrance (cleverly hidden behind a corral of parking lots), one has to follow a wacky trail, indeed, to the new Bellevue. From First Avenue, the main public thoroughfare that brings the visitor by taxi, bus, or foot (the nearest subway is four long blocks away), one is directed to a narrow walkway, covered by the sort of plastic canopy that is used to shield tobacco in the Connecticut River Valley. Enroute, the visitor passes a seven-tiered parking garage of tired concrete, which has clearly metastasized from a primary site in the Trenton of 1960. In conformance with the modern usage of teaching hospitals, the walkway leads to a side entrance of the old administration building (the front portico is bricked up).

Upon entering the makeshift lobby, an antechamber constructed from the confluence of older corridors, one is confronted by three paths: One can move into the

* Dr. Weissmann is Professor of Medicine and Director, Division of Rheumatology, New York University School of Medicine.

coffee shop, a concession which has been designed in the neoformica style of 1970 Milan with later echoes of *l'ecole* Burger King. Or, one can head towards the old chest building. The corridor of this pathway was modernized in the late sixties by an admirer of Charles Moore, the former Yale architect, whose major contribution to the postmodern style was the substitution of random arches or witty diagonals for the traditional square or rectangle. In Bellevue, this esthetic was achieved by snaking sausagelike strips of fluorescent light about scattered baffles dropped from a cocoa-colored ceiling. The remainder of this color scheme is beige and spinach green.

But let us follow the third, or main, route to the new hospital. Because of the stepwise destruction of the old buildings, this corridor runs a U-shaped course at least a city block in length. Its architectural forms (Snap! Crackle! Pop!) derive from the egalitarian devotions of Robert Venturi, who so admired the nocturnal cityscape of Las Vegas. The ceiling is dominated by five brightly flickering strips of colored neon that run the whole length of the corridor. They are color-coded for the several stations of the patient's cross: blue for the outpatients, green for the children's playroom, orange for the screening nurse, and so on. At each station, a similarly colored banner proclaims the destination: Outpatients, Play Area, etc. Hung from the ceiling, the bright fabrics evoke the souks of Marrakesh.

At last one enters the new Bellevue and finds oneself in the Four Seasons. In this lofty lobby, one is finally in the presence of the Health and Hospitals Corporation! Banks of automated express and local elevators, efficient guards, and computer-assisted receptionists confront the visitor amidst blue carpets and polished terrazzo. One notes with dismay the underutilized main entrance designed by the architects of this great edifice. Its wide glass doors open rarely, since the entrance is inaccessible to any of the city's streets. An occasional respiratory therapist enters from a hidden path leading to the nursing school.

The ground floor promenade, however, is exhilarating for reasons other than its melange of architectural eccentricity. For the scene is dominated by the crowds that move along its passages. We are surrounded by the life of our city. The classic Bellevue derelict, with gaping tennis shoes and fading pinstripe trousers, is flanked by a tidy covey of gays with dyed hair and chrome-studded black leather tights. A short, pregnant Hispanic woman is jostled by a crew of hefty suburban ambulance drivers sporting "Rockville Center" quilted on the backs of their nylon jackets. A tiny Chinese scholar is accompanied by a West-Side social worker in space shoes. Two youths in running clothes and stereo headsets accompany a third, already on crutches. A drug salesman in polyester bumps alongside a gaggle of bag ladies. House officers, in khaki and topsiders, mingle with shavenheaded Hare Krishnas. The mass is monitored by ubiquitous hospital police: the gun-toting officers toss pleasantries at a trim nurse or two.

And the signs! In English, Spanish, and Chinese—their messages, first embalmed in the plastic sans-serif iconography that Massimo Vignelli designed for Bloomingdale's, have become modified by notices of clinic openings and closings inked out in Magic Markers. Long "Bills of Patients' Rights," declarations of "Pilferage Control," posters announcing staff lessons and rap sessions devoted to "Spanish," "Good Nutrition," "The Appreciation of Modern Art," and "Rape Victims' Support" mingle with displays of athletic trophies won by the bowlers, runners, and soft ballers among the employees. Pass by all these, and, by means of the automatic elevators, one arrives at last at the real Bellevue—its wards and clinics.

On the upper floors, the aspect changes: Confusion is transformed into clinical order. The corridors are clean, wide, and glossy. Neat signs direct the visitor to spacious rooms that yield stunning views of the river or the Manhattan skyline. Activity at the nursing stations is brisk and efficient, monitors and intercoms scan the life of the wards. We can, if so inclined, experience an epiphany of enlightened social service: The indigent of New York—its domestics and derelicts, aged and addicted—are bedded in clean linen beneath private television receivers. Airy day rooms occupy each corner of every floor, modern prints by Warhol and Indiana brighten clinics and examining rooms. The city has provided a spacious cafeteria and well-stocked libraries for both staff and patients. Rehabilitation has its pool, the intensive care units (coronary and general) are filled with gadgets appropriate to the maintenance of pulse and breath, radiology suites glisten with the diagnostic triumphs of the decade. In the streets below, pavements may crumble, the subways may rust to a halt, the garbage may spill into plugged gutters. Here at Bellevue, however, at least one city service has survived the recent federal war, not against poverty but against the poor.

Bellevue functions as a kind of realization of the social optimism of the early sixties, when energy was cheap and the American Empire was infused with the vigor of Camelot. In those days before Vietnam, under Wagner and Lindsay, New York City had caused to be designed for its poor a structure in which to provide medical care that was to be no less splendid than those glass pyramids that housed its great corporations. I remember when the drilling of the new foundations began. At the time, the Department of Medicine was quartered in the old A and B building (1908)—then only a shabby relic of the splendid design of McKim, Mead, and White. The open balconies on the river had long been abandoned or turned into tatty conference rooms. The fine marble stairwells had cracked. The manually operated elevators were frequently out of action; when not, the call buttons had the classic Bellevue notice affixed:

"Ring Up for Down." At night, the operators being absent, students and interns alternated at running these rusty cages in order to move patients from the wards to X-ray or to other destinations.

The wards, owing to their 1908 design, were large and commodious, but during the winter months anywhere from 30 to 40 beds were tiered in three parallel rows, sometimes spilling into the corridors. The windows were uniformly grimy. In order to permit easier access and observation, the beds of the sickest patients were moved toward the end that had the nurses station. Communication was poor, and house officers sometimes napped next to a very ill patient in the early hours of the morning.

Since the B wing was to the north, where the huge pillars of the new Bellevue were to be sunk, while the A wing was remote from the excavation, cardiac auscultation during working hours was possible only in the A wing. This state of affairs led Lewis Thomas (then Chairman of Medicine at NYU-Bellevue) to quip. "A decade of NYU students will have learned only one aspect of cardiology: B2 is louder than A2."

That phrase of yesteryear summons up not only the transient nature of our craft's terminology, but also the changes that time has worked with respect to disease. The old Bellevue of McKim, Mead, and White was filled with patients who suffered from diseases that we no longer see in our new high-rise by the river. In the three decades of my Bellevue career, the transitions of diagnosis have been as abrupt as those of the landscape. Then, as now, the major social disease was acute and chronic alcoholism with its devastating jabs at heart, liver, brain, and blood. But, during my student and house-officer years, the beds of A and B were also filled with rheumatic fever. Valvular heart disease and endocarditis were found mainly among the rheumatics or the already declining population of patients with tertiary syphilis. Deforming gouty arthritis and tophaceous gout brought in quite a few—and each winter flooded the wards with pneumococcal pneumonias. Iron lungs—the awkward respiratory aids of our era—were stationed outside the pediatric isolation wards to aid in the later ravages of polio. Tuberculosis accounted for the population of an entire building. Indeed, the old chestnut of Bellevue morning rounds was: "This patient is clearly suffering from cirrhosis of the liver, pulmonary tuberculosis, and tertiary syphilis. But what brought him to the hospital?"

Only in retrospect do we recognize that our patients, arranged so neatly in the tiers organized by the planners of 1908, were burdened by diseases that were rapidly waning in incidence. Thanks, in part, to experience at Bellevue and its sister institutions, rheumatic fever and syphilis have yielded to penicillin, tophaceous gout to probenecid and allopurinol, poliomyelitis to the vaccines of Salk and Sabin, and tuberculosis to the successors of

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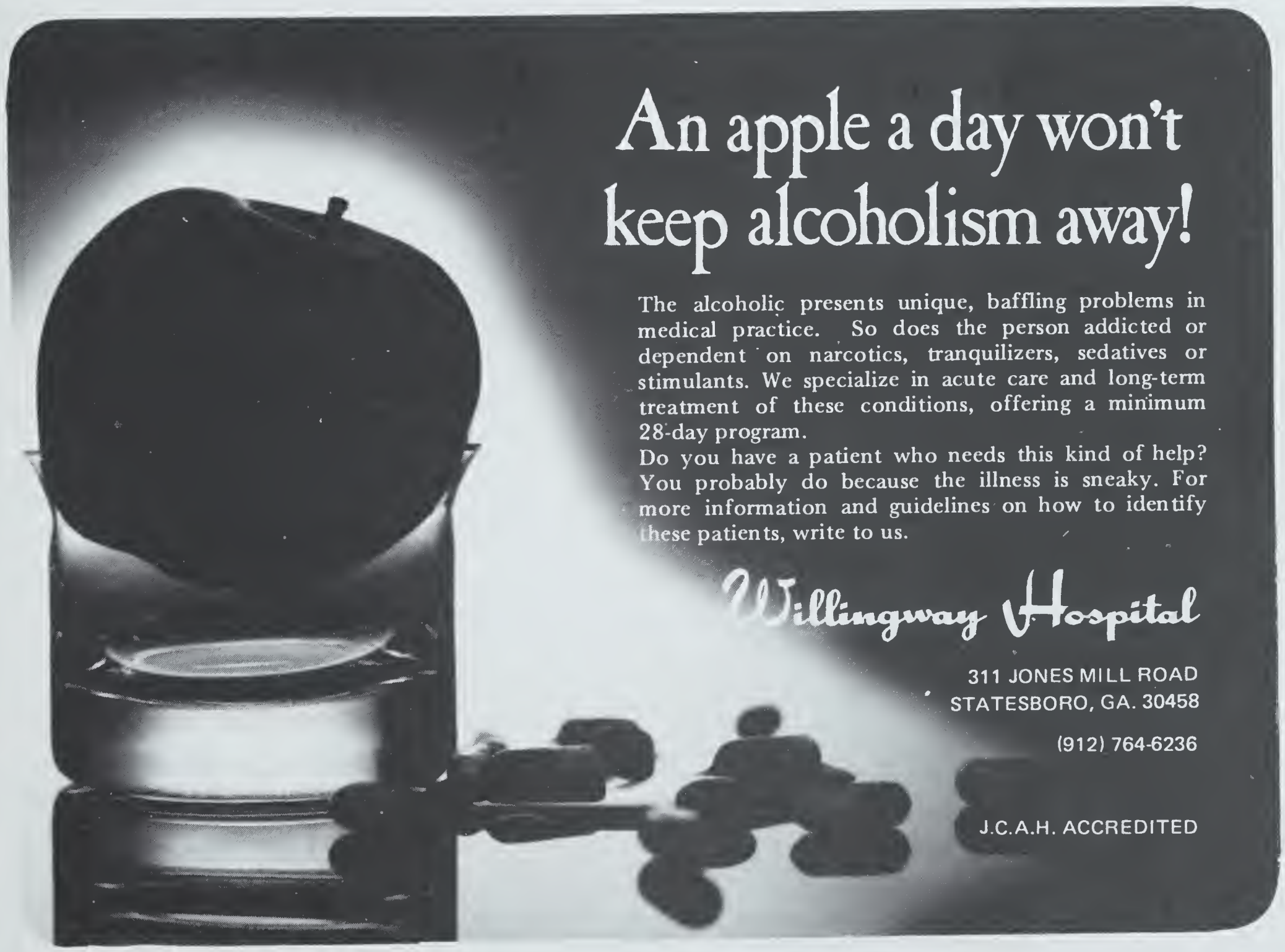
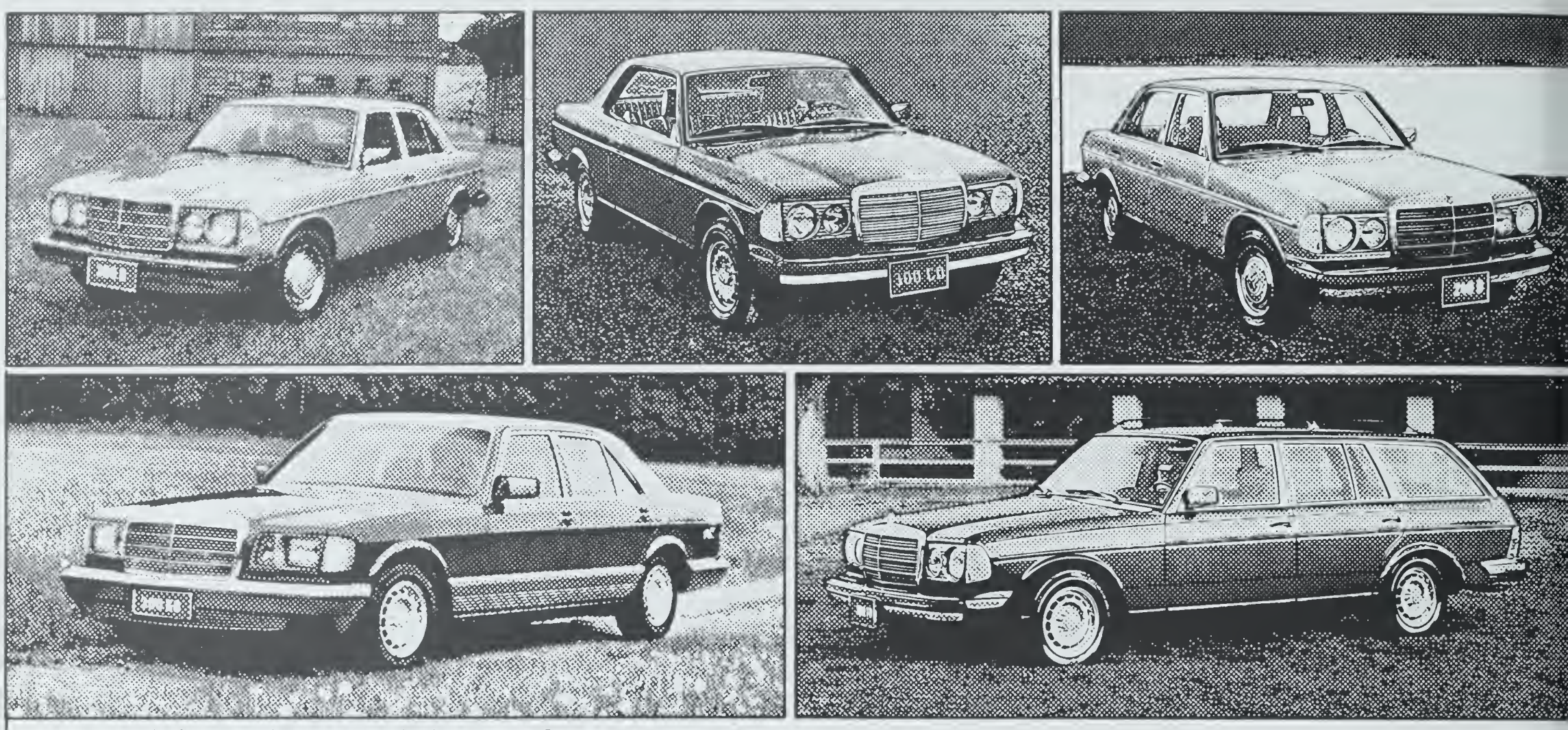
streptomycin. But if these diseases accounted for so many admissions to the old hospital, why are the beds of *new* Bellevue still so full?

Well, to begin with, cancer and the degenerative diseases of heart, lung, and brain are still with us; their therapy (if not, alas, their cure) occupies the attention of man and machine. But it is also true that, like alcoholism, the infective insults of streptococci and tuberculosis were abetted by poverty, dirt, and urban crowding—what the young leftists of 1968 called the etiology of "diseases of oppression." And, since there is little evidence that these social imperfections have been ameliorated, newer diseases of the underclass have begun to replace the old. The "poor" of McKim, Mead, and White's era were the Irish, Italian, and Jewish immigrants of lower Manhattan. Indeed, it was clinical dogma—drawn from experiences at Bellevue and Boston City Hospital—that rheumatic fever was an "Irish disease"; this observation was not based on data adjusted for class or income. In today's Bellevue, the "poor" are black, Hispanic, Haitian, and Chinese. They also include a number of children of the white middle class who have migrated to Manhattan in quest of drugs or the sexual company of their own gender.

We now find our wards filled with cases of "brown heroin kidney," "gay bowel," oral chancres, gonococcal arthritis, the hepatitis of drug abuse or pederasty, the endocarditis relayed by infected needles, and the acute respiratory distress that follows a jet of flaming cocaine. Effects of drug abuse and consequences of ingenious sexual practices are beginning to edge out effects of the traditional abuse of alcohol. We have so much to look forward to!

Here, then, a marriage between form and function in the new Bellevue! The punk-rock entrance to Bellevue welcomes a Rastafarian with infected needle tracks. The neon strips of the Venturi school light up the jaundiced eyes of a slim hairdresser. The psychedelic banner of the screening nurse greets the frightened teenager aflame with speed. And on the quiet corporate floors of the new tower, the professional middle class (students, house officers, attending physicians) sorts out the ranks of those wounded in our social wars. The mugged, maimed, drugged, and infected are victims of epidemics as virulent as those that filled the gracious loggias of 1908. The high-rise columns and modular panels of corporate architecture now house the losers of new urban scrimmages—for whom there is no place in the similar towers of Wall Street or midtown. In both the old Bellevue and the new—and for this reason there is perhaps no more engaging hospital in which to work—we have been able to appreciate not only *what* happens in disease, but to *whom*. The setting of our encounter was, and is, entirely appropriate. The forms of our buildings spell out the social litany of their function. It is often a sad and always a confusing refrain.





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Mrs. Rufus E. Lee, Jr.
President, A-MASA

SEX EDUCATION:
MORAL, EDUCATION OR MEDICAL ISSUE?

How do you feel about sex education in schools? It is the basic right and duty of parents to teach their children what they should know about their bodies. They should be taught how to treat their bodies nutritionally, physically and spiritually.

There is evidence that this is not being done effectively across the nation but particularly in the State of Alabama.

Who is doing most of the sex education? It is parents, schools, or the media? Does your child watch TV, go to the movies, or listen to music? If so, J. R., Robert Redford, Burt Reynolds, Jane Fonda, and KISS (a rock group) are teaching them. Even the soaps give a very explicit sex education, which if taught in a classroom would create considerable controversy.

Some months ago, I was invited, as President-elect of the Medical Auxiliary, to attend a Teenage Pregnancy Conference in Montgomery. There were probably a thousand people in attendance—educators, Pensions & Securities case workers, Public Health officials, physicians, and interested volunteer organizations.

Until this time I had not been aware that we needed so much sex education in our health education classes. With that number of people concerned I decided to learn more about the problem. Statistics had been printed many times and were startling.

- There were 14,033 illegitimate births in 1980.
- Alabama ranks #3 in teenage pregnancy.
- White teens show the largest increase.
- 1/3 of all abortions are obtained by teens (up by 60%).
- 1/3 of all children born to teens are abused.
- 84% of teen patients of Public Health offices are on some type of birth control (most widely used contraceptive is HOPE).
- V.D. was up by 70% last year and the highest rate of increase was among boys and girls 11 to 15 years of age.
- Maternal death rate is 60% higher for young teenagers.
- Babies born to teenagers are 2 or 3 times more likely to die before 1 year of age.
- Pregnancy is the most common cause of school dropouts.
- Toxemia is 3 times greater in teens under 15 years of age.
- It has been estimated that half of all teenagers have sexual intercourse before they finish high school and 3 out of every 10 girls will become pregnant.
- Every illegitimate baby cost the State, Federal, and local authorities an average of $18,000.00 over a 20-year period in medical and welfare benefits.

The Public Health office was enormously helpful in supplying these statistics. These are all astounding statistics and we truly need to concern ourselves with the problem and come up with answers.

Most of us think: "What can I do about that? I must be more aware of my children's morals but every parent must take care of their own."

Isn't it obvious that we, as parents, medical Auxilians, and physicians need to do something? Doing Nothing is More of a decision.

It is indeed a Moral Issue, A Medical Issue, and an Education Issue.

Yes, we can teach our own children all we know about each issue but we must do more. We can encourage teaching moral and spiritual values in our churches, through community and religious organizations. However, it is impossible to reach those who do not attend these functions.

We need our already too busy physicians to volunteer more of their time to teaching the medical pitfalls of teenage sexual relations. Never turn down a chance to speak at schools, civic groups, churches, and youth organizations. Take every opportunity with a teenage patient to let them know where their problems could be and give them a chance to ask questions. You may be the only one they can talk to. Handouts and booklets are available and helpful.

Continued on next page

AUXILIARY *Continued*

The medical auxilians in many counties have been working for many years trying to educate young people on their responsibilities to themselves and to others. They have furnished schools with sex education films and other materials. Hopefully, more will become involved in the future.

And, oh yes, we do need health education in the schools with particular emphasis on sex education. The school is the only place all teens go. We must teach the (parentally taught by example) sexually active 11 year old how to avoid V. D. and possible pregnancy. We must teach them about child abuse.

And by all means teach every child and teen that *LOVE* not sex is the key to acceptance.

Mary Julia Lee

Victorian, Patronizing, Condescending, Arrogant and Antiquated

Editor, The Journal:

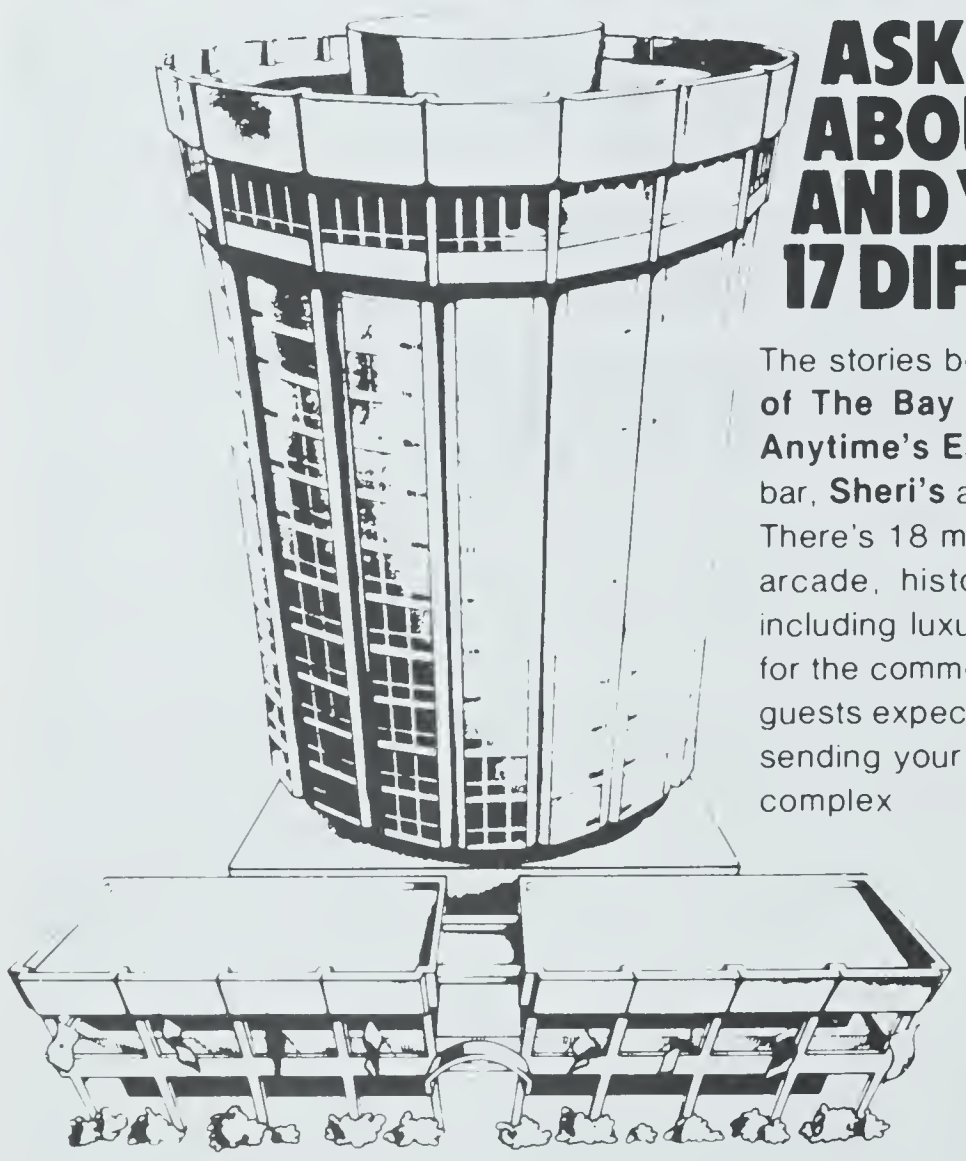
As a female physician encouraged to pursue a career in medicine by my (male) family doctor, I am disgusted and offended by Dr. Brown's article in Vol. 51, No. 1. His view of men and women in parenting is nothing less than Victorian and nothing more than patronizing and condescending toward women.

One of the statements that infuriates me the most is "Mother's . . . best faculties can never equip her to struggle with the world outside her home." Does this mean I practice medicine incompetently, or break down and cry after seeing patients all day? Of course not! Neither I nor any other woman is the spineless quivering mass of nerves Dr. Brown tries to depict.

Surely you printed this article for a laugh, a time-machine peek into the arrogant, antiquated, male dominated past.

Sincerely,

Lynn Anderson Jetton, M.D.
UA Class of 1975



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The stories begin with great places to drink and dine. The gourmet **Top of The Bay** - an evening with a starview. Down to earth there's **Anytime's Eatery** open 24 hours a day, and the ultra chic lobby bar, **Sheri's** at the Sheraton. But that's only a few of the stories. There's 18 meeting rooms for 10 - 800, the plaza shopping arcade, historical tours, 206 newly decorated rooms including luxurious suites and specially designed rooms for the commercial traveler. Plus all the services your guests expect. You can get all the great stories by sending your guests to Mobile's complete hotel complex

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GET ON THE TRACK FOR FALL 1981

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Sheraton Riverfront Station

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200 COOSA STREET, MONTGOMERY, AL. 205/834-4300

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General*: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Bactrim™ succeeds

in recurrent urinary tract infections*

from site to source

Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1] . . . the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1] . . . and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med* 303:426-432, Aug 21, 1980. 2. Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS

160 mg trimethoprim and 800 mg sulfamethoxazole

DOUBLE STRENGTH TABLETS

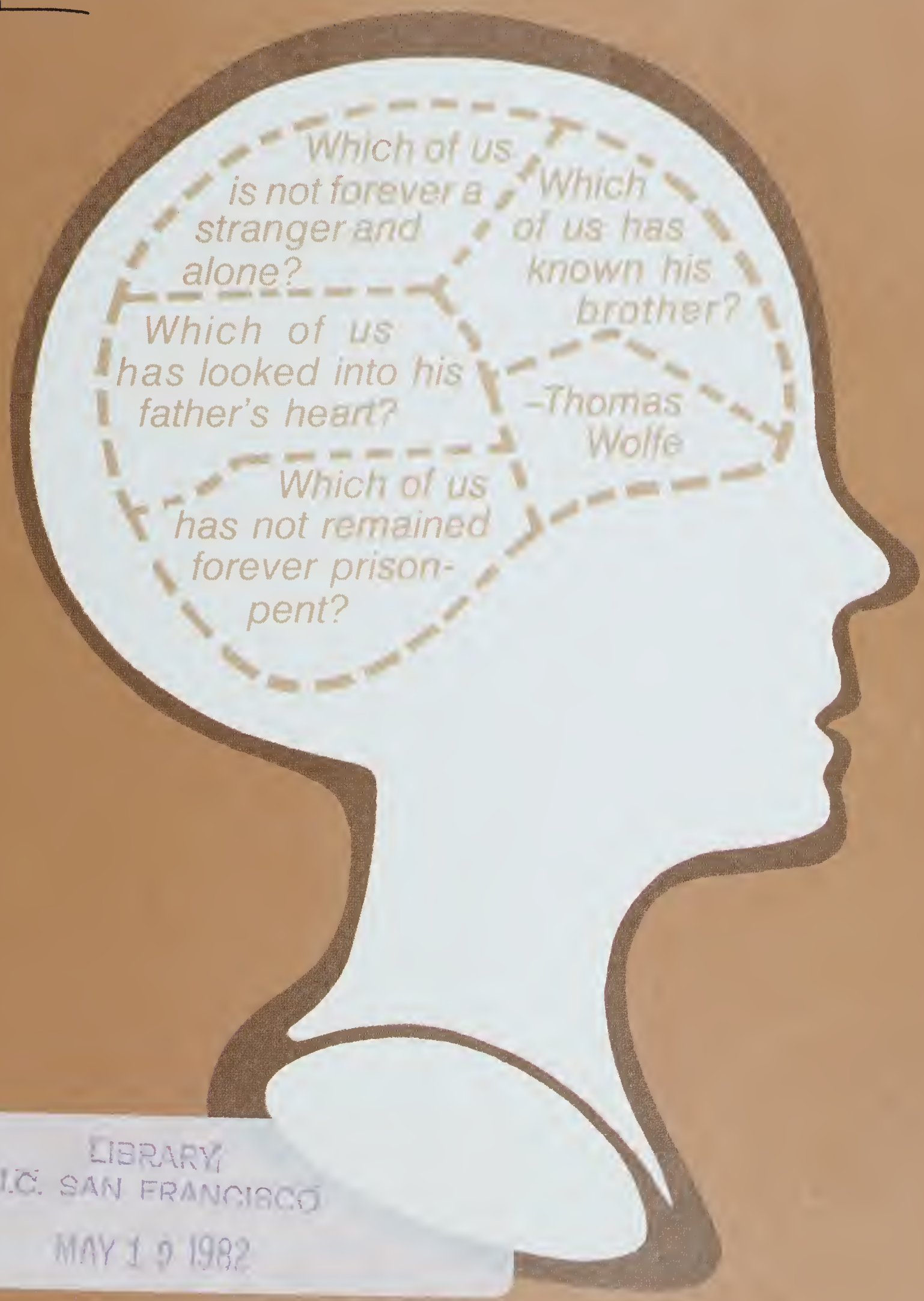
maximizes results with B.I.D. convenience

ROCHE®

*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

JOURNAL
of the Medical Association of the State of Alabama
VOL 51, NO. 4, OCTOBER, 1981



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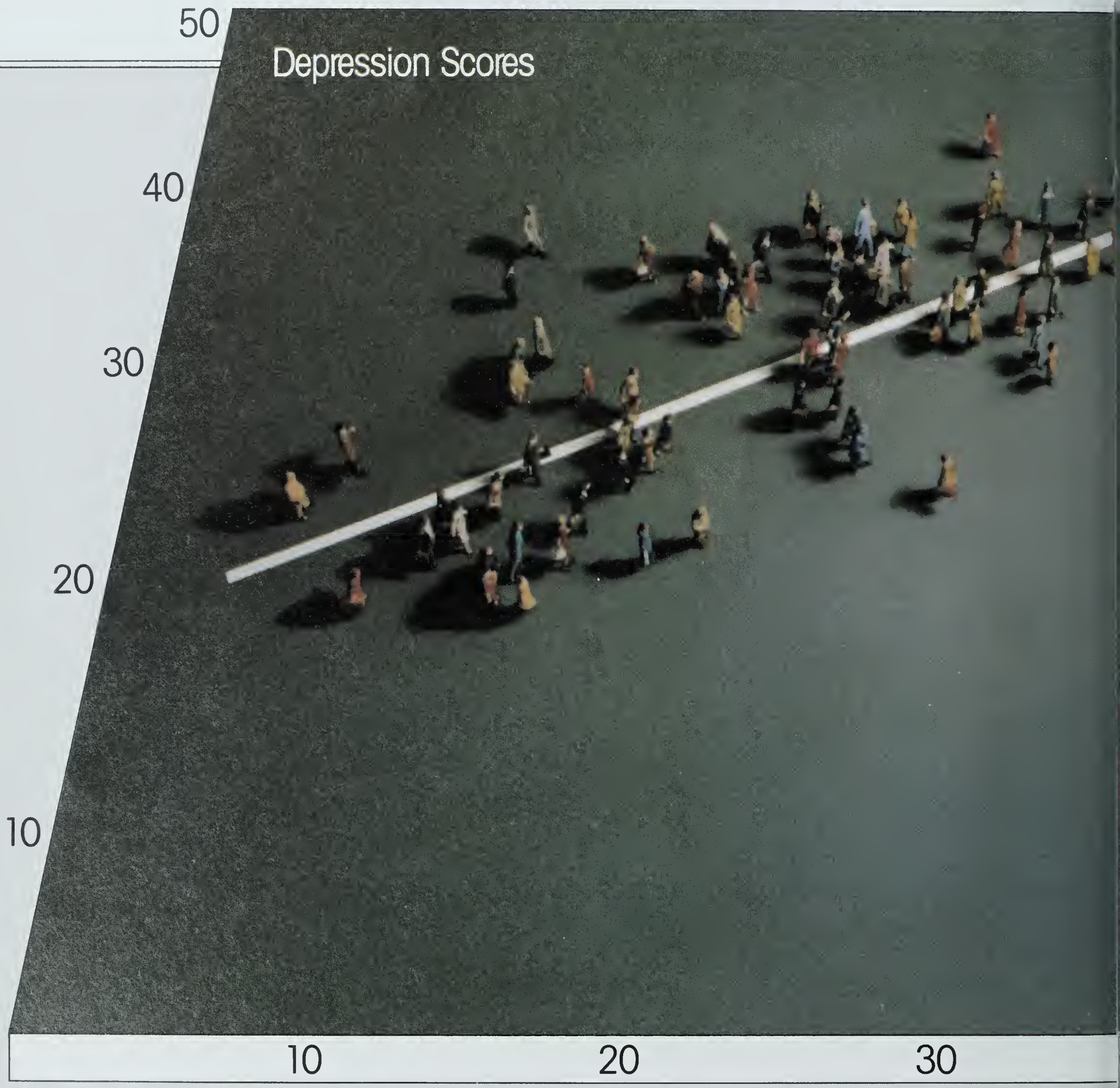
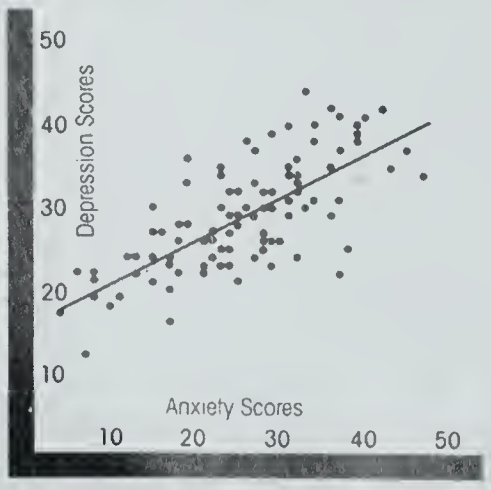
THOMAS WOLFE: A PSYCHIATRIC VIEW

See page 11

FOR THE 7 OF 10 NONPSYCHOTIC





Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3]Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

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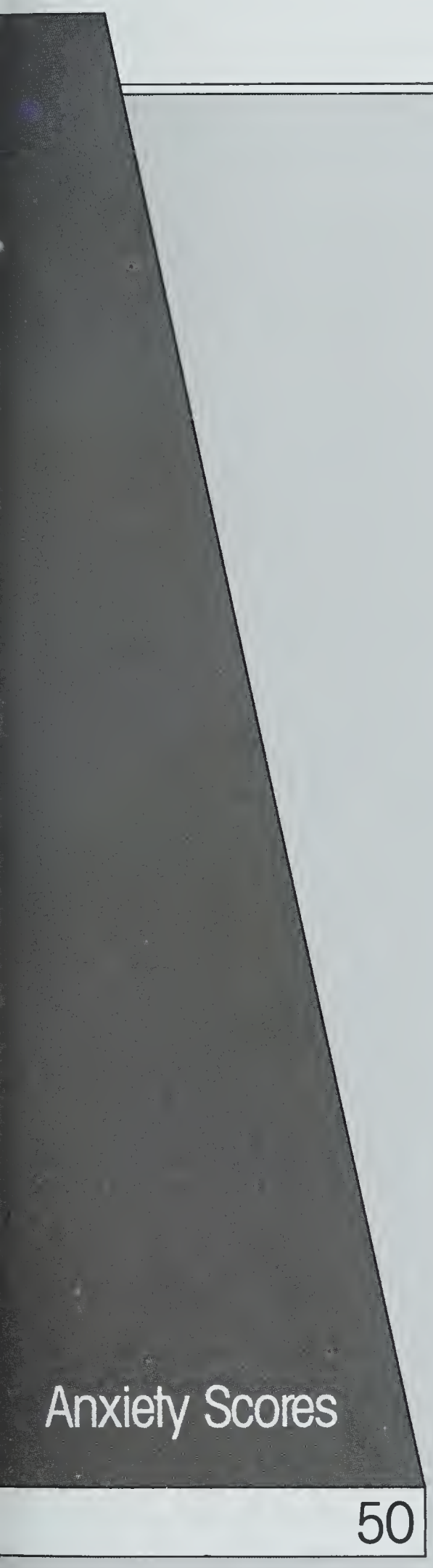
DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]



Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35:*1359-1365, 1978. **3.** Claghorn J: The anxiety-depression syndrome. *Psychosomatics 11:*438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137:*1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61:*217-225, 1979.

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.
In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
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THE DOCTORS' LAWYER

You probably read in The Alabama M. D. recently about the talented and experienced attorney, Wendell Morgan, who will be officially replacing Jack Mooresmith as MASA General Counsel come January. Wendell has been on board since September learning the lay of the land from Jack, who is leaving us after eight years to enter private practice in Mobile.

The role of MASA General Counsel is a complicated and demanding one. This seems as good an opportunity as any to outline some of its dimensions. To begin with, the job calls for two big hats. The General Counsel also serves as Counsel to the Board of Medical Examiners, in which capacity he is an Assistant Attorney General of the state.

Wearing that hat, he functions as the prosecutor in disciplinary and revocation procedures. He advises the Board on matters of legal compliance in questions arising over applicants for licensure. He advises the Board and its investigators on the handling of controlled substances. And so on.

As MASA General Counsel, our attorney spends much of his time researching the law and advising the Board of Censors and staff on the potential liability of anticipated actions. He must assess risks, advise on them, then actively implement any action decided on by the Board.

He is also a walking authority on the Association's Constitution and Bylaws and, as such, cannot shirk from telling the Board and individual members that a proposed course of action is without constitutional authority.

During the month, when the Board is not in session, the General Counsel is the staff's authority on all law and regulations, both federal and state. He is expected to know all Association organic law, as well as state and federal statutes, regulatory rulings, case law and the latest dispensations from an otherwise obscure administrative law judge sitting in Oshkosh or Bangor.

When he is not so occupied, he is expected to field all manner of questions from members in private practice about their own legal questions, particularly those involving liability. He speaks at seminars, advises medical assistants at risk management symposia and serves as coordinator of Peer Review activities.

Mr. Mooresmith will pass the torch to Mr. Morgan on four continuing lawsuits of considerable importance to the Alabama physicians. They are:

Wood v. Graddick—An attempt by podiatrists to invalidate the statutory limitation on the practice of foot surgery. They want the present podiatric limitation to the phalanges and the metatarsels declared unconstitutional, giving them access to the tarsels or ankle. If podiatrists are successful, other limited practitioners may follow the precedent. Depositions have been taken around the country.

MASA v. Schweiker—The federal court case in which MASA has challenged the administration of the community health program in Alabama. Briefs and arguments have been filed on the question of whether MASA and private physicians have legal standing. The future location and operation of clinics may hang on the outcome of the suit.

Kulkarni v. Board of Medical Examiners—A lawsuit filed by foreign medical graduates seeking to nullify statutory licensure requirements for FMGs. Briefs have been filed and oral argument is scheduled on a motion to dismiss filed by the Board.

Boone v. Mullendore—An appeal pending before the Alabama Supreme Court in which MASA has filed an amicus curiae brief in support of Dr. Mullendore. Dr. Mullendore is alleged to have been negligent, with the result that Mrs. Boone gave birth to a perfectly healthy child. Mrs. Boone is suing Dr. Mullendore for the future cost of raising and educating her child. Oral argument is expected soon.

From this brief outline, you may see that MASA's General Counsel is a busy man. If you take each of the above cases and duties as the tip of an iceberg, I believe you will see that "our lawyer" spends many a lonely hour plumbing the icy waters beneath.

S. Lon Conner
Executive Director

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INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

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J. Kendall Black, Jr., M. D.
President

PRESIDENT'S PAGE

THERE AIN'T NO FREE LUNCH

Leon Samson made the point that America is a nation built on ideology. He wrote, "When we examine the meaning of Americanism, we discover that Americanism is to the American not a tradition or a territory . . . but a doctrine. . . ."

Samson was right and therein lies the foundation of America. This country was established around the pervasive, almost monolithic, commitment to individualism, freedom, equality and democracy. Our entire constitutional arrangement was based upon the separation of powers (executive, legislative and judicial). Underlying this entire arrangement then and now is our classical distrust of power and the answer to the problem of power: disperse it and limit it.

Yet as this country has grown we have seen a progressive intrusion of federal government and to a lesser extent state government into our lives. The profession of medicine has been no exception to this rule. As the HSAs have evolved, their demographics have been dictated by federal by federal bureaucracy, their health plans have had to meet federal regulation and the entire state program must seek federal approval each year. Many of the applications for grants which they have had to evaluate have been for federal funds. The applicants seeking these grants must meet federal rules and regulations, submit to federal form and bureaucratic evaluation.

Mr. Reagan was elected with a very basic commitment to "get the government off the people's back." That's all well and good as the statement reads and a very commendable position indeed. However, a few recent items might cause one to question the dedication of this administration to such a position. For example. Robert Rubin, assistant secretary of HHS for planning an evaluation, said "thoughtful, prudent, anti-trust enforcement is needed to foster competition in the medical field as elsewhere." Mr. Clanton, the acting chairman of the Federal Trade Commission, in his remarks to a recent meeting in Washington D. C., stated "in this instance I am especially pleased to look ahead because I believe that the commission will continue to play a vital role in the continuing evolution of anti-trust law and public policy directed toward enhancing competition in the financing and delivery of health care services."

Let's look at the block grants, for example. The State must develop a plan for the use of those funds, it must hold a public hearing on the proposed use of the funds and must submit to an audit of fund expenditure by a method acceptable to the feds after they have approved the state plan for expenditure of those funds.

The so-called pro-competition bills now before Congress, while altering the tax structure of health plans, would define qualified health plans so that they would have to offer a minimum set of "basic health care services." These would include all of the appropriate levels of care and would require that the plan be approved either by the Secretary of HHS or a federally devised health benefits assurance corporation

Mr. Gephart's bill would even develop a specially designated United States health court as well as a United States health court of appeals. Certain of their proposed new regulations regarding Medicare and Medicaid would authorize the secretary to allow states to apply for waivers to bypass the freedom of the Medicaid recipients to choose their own providers. The program would then be able to negotiate the fees with

Continued on page 38

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THOMAS WOLFE: A PSYCHIATRIC VIEW

By Claude L. Brown, Jr., M.D.

Some years ago, Claude L. Brown, Jr., M.D., Mobile psychiatrist, was asked by a student to provide some pyschological insights into the character and art of Thomas Wolfe, whose life she was researching.

Wolfe died in 1938, after producing several novels of great promise. That he never realized this promise, many critics think, had much to do with his failure to discipline and contain his enormous talent. Had it not been for the brilliant editing of Maxwell Perkins, it is entirely possible that Wolfe's novels would have never been published, such being the raging flood of words that had to be reduced to manageable size.

Dr. Brown, reluctant to offer a professional opinion on Wolfe, nonetheless complied, prefacing his remarks with a careful disclaimer to any personal knowledge of Wolfe beyond what was known of him and through his writings. Dr. Brown's manuscript follows—Ed.

May 15, 1967

Dear Sue:

Thank you for the opportunity of contributing to your study of Thomas Wolfe. Your eleven pages of description of Wolfe's traits are informative and represent much delving by you.

I must make a prefatory disclaimer. In a short psychological study like this, one can't assume that he is being too profound, too correct, or too inclusive. I mean that a comprehensive, penetrating psychological analysis of Wolfe's personality functioning would necessitate a thorough-going research endeavor—which I am not prepared to undertake. For instance: if one makes assertions, he should substantiate them; examples to corroborate statements and opinions, annotations, chapter and verse, etc. should be ready at hand, and should frequently be cited. In such detailed form I am incapable of elaboration. I give you, then, my view of Wolfe with the admitted reservations above indicated.

Further; it is generally recognized—and I place great emphasis on this fact—that although one may draw certain conclusions from data, and that these conclusions may be broadly correct, yet the ineffable essence of a person is apt to remain shrouded in mystery. This, indeed, is the fascination of the study of people—like all of life so much remains unspoken, unseen, not to be caught in a net of words, regardless of how well the net may be cast.

Thomas Wolfe was a quite neurotic person, with major fixations of libido in the oral phase of his development. The causes of this fixation were probably the ones usually operative in such a picture: marked gratifications alternating with marked frustrations in the early years. Sleeping with mother until 9, she keeping him in curls for years, nursing him until he was 3½, he being the youngest and mother keeping him to her breast so long.

Which of us has known his brother? Which of us has looked into his father's heart? Which of us has not remained forever prison-pent? Which of us is not forever a stranger and alone?

–Thomas Wolfe, Look Homeward, Angel!, 1929

The principal themes in his work and in his life revolve, I think, around the primitive aim of regaining this infantile paradise and the resultant immense frustration that ensues when such primitive gratification is denied. For instance: the intense nostalgia in his works. Now it is true that the concretization of experience, the effort to find in some more permanent form that which, if not caught, would fade into gossamer nothingness, is an old aim of all art. The enshrinement of affect, as it were: to put into lasting, ever available form that which is transient—an effort to catch the fleeting moment.

(*'Verwlile doch, du bist so schon'*–Goethe). This is a human, as well as an artistic aim. But overdone, it becomes neurotic. Wolfe forever speculated a return to some brighter land, to a halcyon day ('O lost, and by the wind grieved, ghost, come back again'. Wolfe)

He, as did many other American writers, went to Europe. But he, unlike any others, preferred German. Why? I wonder if he preferred Germany because of it being the well-spring of romanticism—because some of its great writers emphasized the youthful romanticism that was such a part of Wolfe. Also, he probably like the German beer. And he almost certainly felt a kinship with the spirit of abandon that the Dionysian riotousness of the Munich Octoberfest produced.

Surely he shares many of the sentiments of the young Faust: wishing to encompass all of life, all experience—all books, all places, all women.

(*'Ich bin nur durch die Welt Gerannt;*
Ein jed Gelust ergraff ich bei den Haaren,–' Faust)

By his own statements, Wolfe wished to absorb all of life—and he was so intent on this that he never learned another message that came to Faust: that one can never comprehend, much less live, the universal life. That one is defined by his finite self, by the time and circumstance of his single brief life. Wolfe, in his oral incorporative efforts, never learned this.

All this is related to another cardinal feature of Wolfe: his frequent depressions and disillusionment. For the other half of the romantic moment is always disillusionment (Hegel). In general, romantic love is the necessary and exhilarating precursor of a more mature relationship. Romance is the first bright flame of a fire that one hopes will burn always. But the fire cannot remain incandescent; it must subside to a steady glow. Wolfe, out of his tremendous primitive needs, wanted the fire to blaze constantly. It could not, since it never can—and when this occurred he was devastated.

When reality intruded into his fantasied gratifications he reacted with incomprehension, frustration, despair, and misplaced anger.

"Why was it that, with his fierce, bitter and insatiate hunger for life, his quenchless thirst for warmth, joy, love and fellowship—that he grew weary of people almost as soon as he met them? Why was it that he seemed to squeeze their lives dry of any warmth and interest they might have for him as one might squeeze an orange, and then was immediately filled with boredom, disgust—? Where did it come from—this unfathomable and yet unshaken conviction—that the enchanted world was here around us ready to our hand the moment we chose—and that the impossible magic in life of which he dreamed, for which he thirsted, had been denied us . . .?" (Wolfe—*Of Time and the River*)

He lacked in large degree the organizing, synthesizing, coping with reality functions of a relatively intact ego. He was personally sloppy, tended to his bodily needs haphazardly, was immensely disorganized in his work habits, always struggled with time, and was totally vulnerable to any whisper of adverse criticism. He operated mainly out of archaic processes which know no realistic limits.

But archaic processes have tremendous drive, and Wolfe palbably had power. "Life does not come to me evenly or gently. Do not deceive yourself. You can teach me no balance, equipoise or moderation. Nothing will be gained by putting a fence around me: I will but burst forth the more intemperately at the end. My life is a rude, rash gamble—a curse and a care . . . ." (Wolfe—Letter to Prof. Baker—prob. 1923).

He was right. No fence was ever put around him. And he remained incapable of disciplining himself. Whether this was a tragedy or not I cannot guess. If it had been otherwise, then it would not have been Wolfe. He could never attain objectivity in his work: this fact he rarely recognized, and could never give it more than intellectual acknowledgement.

For his writing was the main process by which he tried to deal with his conflicts. His works do have much vigor and drive. At times, he is poetic (he wished to be a poet, but his poetry is limited due, not to any lack of fertility, but a lack of discipline, coherence).

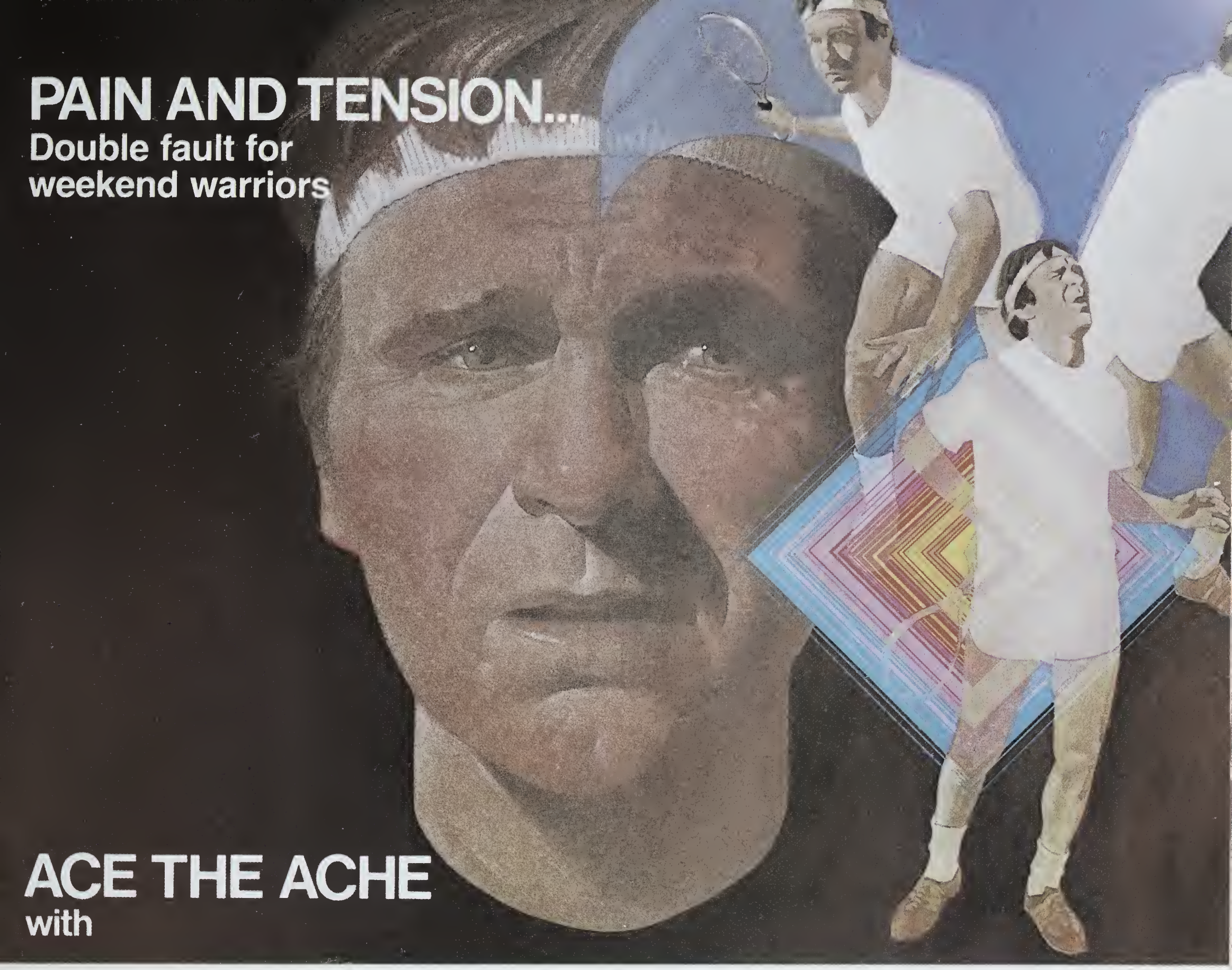
I do not think that he was truly concerned with social phenomena. He was far too self-preoccupied to be interested in anything beyond the limits of his immediate sensibility. Indeed, this lack of expansion of horizon is a frequent, apt criticism of his work. All his writings concern nothing but his feelings. His theme, forever, is himself. And it becomes boring—which is why his first novel is usually the only one remembered keenly by his readers.

The frequently expressed idea (even by him) that he was "in search of a father" is misleading. That he sought external sources of support to an inordinate degree is well-known. His relationship with Maxwell Perkins is such a search for help. With Wolfe's disorganization, both in his personal lfie and in his work, it is doubtful if he could ever have been published without the Herculean help given him by Perkins. Wolfe fed upon Perkins for 8 years, and finally repudiated him. The Hostile-dependent nature of this relationship is clear. Perkins could never understand the real causes of Wolfe's break with him and with Scribners; he could not understand it because he tried to comprehend it rationally and the problems stemmed from unreality, i.e., Wolfe's engulfing, insatiable needs that could never be met.

Wolfe quickly tried to establish a similar relationship with others.—"And honestly, Mr. Linscott, what I need most of all right now is someone I can talk to. It will take a long talk, a lot of talk, maybe a whole series of talks but that is what is needed first." (Letter to Robert Linscott, of Houghton Mifflin, 1937). He never did find such a figure, and he was never again able to be productive to any degree.

But beyond the search for the father was the search for his own identity, the effort to establish his ego-intactness, the attempt to establish himself as a man with his own masculine prerogatives. I do not think he was successful in this search. He never became post-ambivalent. In fact, after the devastating rupture with Perkins, I believe that he deteriorated. To be sure, he lived only a brief while and what his final integration would have been had he lived longer remains imponderable. But he gave no indications of a more mature orientation.

He never established a reasonably mature heterosexual relationship. The longest such involvement, with Aline Bernstein, was with a woman who functioned in a nurturing, sustaining role. There was little likelihood that their affair aimed at marriage. There is no indication that he ever came close to marrying anyone. While nothing



Equagesic®(IV)

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101
TM

for mild to moderate pain

Wygesic®IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e g driving a car or operating machinery Patients should be cautioned accordingly
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS
The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I V , simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended.

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indicates any overt homosexuality, he probably had much latent homosexual conflicts. His passive-dependency (which at times was not so passive, but voraciously seeking), his frequent heavy drinking, his inability to establish close relationships with marriageable females, his lasting friendships with older ineligible females (Mrs. Jelliffe, Mrs. Roberts, Mrs. Bernstein) all bespeak a less than masculinely assertive person.

Rather than calling him 'oversexed' I consider that his sexual relationships corresponded quite well with the general pattern of his close dealings with people, i.e., they, too, were grossly immature. Sexuality is not to be separated from the rest of an individual's behavior; it is an integral part of a larger picture. The picture, in Wolfe's case, is consistent.

Wolfe had no wisdom, no philosophy to sustain him in the storms that raged in his psyche. People were good in so far as they were giving to him; they were bad when they did not fulfill his infantile needs. He never progressed beyond the groping understanding of the growing child: that the world was really not quite as it looked; that evil did exist; that some people were hypocritical. He remained struck with this data, against which he railed at enormous length. That mother's milk was not forever available was a monstrous calamity, for which an often reprehensible world was excoriated by him.

Wolfe could delineate character—some of his characters are truly three-dimensional and pulsate with life—but few, if any, of his characters grow. Eugene Gant—George Webber is an entirely believable person, but he does not grow in understanding, or in the reflection of understanding in any increased constructive relatedness with people. He grows older, he changes the scheme of his involvements, but the inexorable neurotic restrictions remain unaltered and produce similar frustrations. In short, his severe Oedipal conflicts always hampered him grievously. Just so with Wolfe, himself.

Wolfe's intense need to write was his urgent expression of self-help. That it took the form of creativity is our gain. Alone, Wolfe was mostly ineffectual. Whether he can be considered a true artist is a question. It is no question that he had, in large degree, some of the prerequisites of an artist: sensitivity and the faculty of expression in some acceptable art form (writing) which has a wide appeal. But the true artist must filter the raw material, shape it with his own tools (whatever the medium), impose form and a kind of meaning to the heterogeneous mass of personal impressions. Could Wolfe, without Perkins, have done this? No one knows—because there *was* Perkins.

His belief in himself (which had marked fluctuations) was well-founded, in the sense that, operating predominantly from id-forces his output and energy were great. But his half-understood realization that he lacked the necessary ego resources (of synthesis, regulation, balance) caused him to perceive the weakness in form and ultimate meaning of his explosive desperations. This realization produced some of his self-doubt.

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ATTENDING STAFF PHYSICIAN, Emergency Department. Excellent opportunity for experienced/interested physician in the field of Emergency Medicine. University Medical Center teaching hospital is seeking a physician for clinical and teaching duty in the Emergency Department. Superb staff support provided. Role includes direct patient care, supervision of housestaff during rotations in Emergency Department and interaction with various specialty services. Will also be involved in planning and development of clinical research programs in Emergency Medicine. Should be board eligible/certified in Internal Medicine. Send resume to Frederic G. Ransom, M.D., Medical Director, University of Alabama Hospitals, Emergency Department, 619 South 19th Street, University of Alabama in Birmingham, Birmingham, Alabama 35233. University of Alabama Hospitals is an Affirmative Action/Equal Opportunity Employer.

Continued on page 42

GRADUATE MEDICAL EDUCATION IN MOBILE

1859-1981

Research by Carol A. Brough Jordan
Office of Media Services/Public Relations
University of South Alabama Medical Center
Mobile, Alabama

The Journal of the Medical Association of the State of Alabama published an article in 1939 entitled "Alabama's Heritage From The Medical College of Alabama." Mobile physician Toulmin Gaines contributed a history of the Medical Department of the University of Alabama, Mobile, 1859-1920 in which he concluded:

"As to Alabama's heritage, it is two-fold. An undying heritage is in the example set by cultured, erudite and lofty-minded men, who strove to pass on the torch of learning to light up the lonely places of our land. "And the second is like unto it," in that this noble effort resulted in supplying the uttermost parts of our State with men who knew the healing art; and who practiced it with the high ideals derived from the emulation of their eminent teachers. The old college received many obscure young men from small settlements and sent them back home to be a power in their communities. "Yea, a very present help in time of trouble." But his is a dying heritage for there is now a dearth of doctors in the rural districts of our State. We all agree that something must be done but has not the old medical college of Mobile pointed the way?"

PREFACE

The first medical college in Alabama was founded in 1859 by Dr. Josiah C. Nott. Built near the second-oldest hospital in the United States. the City Hospital of Mobile (1830-1966), the medical college opened with 111 matriculants. Its second session opened with 120, but the Civil War put an end to its activities until 1868.

Dr. Nott was fully convinced of the many advantages that would result from the existence of a good medical school in Alabama and especially in Mobile.

Willis Clarke wrote that Dr. Nott was "ably supported in the founding of the medical college by the genial and erudite Anderson, the quiet and efficient Ross, the courteous and accomplished Ketchum and others not so widely known who nevertheless rendered valuable aid."

The Medical College was organized with Dr. William H. Anderson as the first Dean and Dr. Nott as Chairman of Surgery. The first graduation was held March 7, 1860.

In March 1907, the Alabama Legislature adopted an act which vested ownership and control of the Medical College of Alabama in the Board of Trustees of the University of Alabama. The act provided that the institution should be known as the "Medical Department of the University of Alabama."

The 1907 act was amended in 1915, eliminating the clause providing that the Medical College should remain at Mobile "for all time" and provided instead that the college should remain at Mobile" so long as it can be maintained in that city as a Class A school of medicine as defined by the Council on Medical Education of the American Medical Association."

In 1919 the Council on Medical Education put the school in Class B and in 1920 classes were suspended at Mobile. The equipment, museum and chemicals were moved to the University campus at Tuscaloosa.

"As the Medical College of Alabama was removed from Mobile in 1920, it became necessary to replace the visiting staff from that college by a regular staff, and this was done, the new staff composed of men selected by the Hospital authorities from the reputable members of the medical profession practicing in Mobile, taking up its duties on the first of October, 1920. This staff serves in rotation for periods of three months, in accordance with rules made by the American College of Surgeons for such hospitals as wish to be rated by it in Class S, a rating which the City Hospital attained."[1]

In 1932 the county was required to contribute to the operating funds of the Hospital and in 1955 other cities within the county assumed financial responsibility, with the name changing to "County Hospital." In 1959 the name was changed to "General Hospital," the same year the Daughters of Charity, who had operated the Hospital since 1861, were relieved of their duties at their request.

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On June 16, 1966 sixty-one patients, only one of whom was a private patient, were moved from the old Mobile General Hospital to the new facility on Fillingim Street.

Financial problems plagued the hospital operation, but the community's leaders were quite aware of the problem and undertook an active program to relieve the situation. The county's legislative delegation declared its intention to prepare a plan that would provide needed funds for operation of the Hospital.

In spite of operational problems, the staff continued to provide services to the community and time after time the excellent staff of interns and residents was the factor that made the difference between life or death to Mobile citizens. In telling the community of the value of the hospital's educational programs, Dr. C. William Daniels, then Director of Medical Education, pointed out in a newspaper article that the medical education program played a major role in keeping physicians and nurses in this area. He also related that the 40 interns and residents provided 24-hour service in the hospital.

With the growth of the medical education program, the hospital employed three full-time physicians in 1967: Dr. M. Lory Campbell, Director of Medical Education and Drs. Hollis Wiseman and Jerry Jordan, Co-Directors of Pediatrics.

Dr. Jordan had a new challenge in his primary purpose for coming to Mobile and that was establishment of a Heart Catherization Laboratory. This would mean that heart patients would no longer have to go to New Orleans or Birmingham for diagnostic work. Hospital Administrator Winston Whitfield announced that the hospital also planned to make this facility the first in the hospital's plans for a complete heart facility.

In 1969 a milestone was reached when the Hospital Board announced the employment of Dr. Billy M. Hightower as a full-time staff member who would direct the hospital's open-heart surgery program.

Progress continued and funds were provided by the Hospital Auxiliary for an expensive Intensive Care Nursery. In an effort to keep the quality of service high and costs down, the Laboratory became automated. Pathologists Drs. Ernest Brown and Edgar Fonde were pleased to point out that this automated equipment would do the work of four or five technicians.

In February 1970 Governor Albert Brewer announced that a medical school would be established in Mobile and it was agreed that the presence and availability of Mobile General Hospital as a base for its establishment had been an important factor.

On January 1, 1971 the Mobile General Hospital became part of the University of South Alabama. In May that year, Dr. Frederick P. Whiddon, President of the University of South Alabama, announced that Dr. Robert M. Bucher had been appointed Dean of the College of Medicine.

The Medical College and the Hospital were of great aid to each other. The free wards of the Hospital and the dispensary of the College furnished abundant clinical material for the instruction of students and the Hospital benefited from the services of the College.

"The interest in medical education existed in Mobile long before there ever was a university." Robert M. Bucher, Dean of Temple University School of Medicine 1958-1969, was attracted to the newly organized graduate medical school in Mobile for reasons he calls unusual.

"There were two unique aspects about this hospital. An open staff arrangement existed in which most of the physicians in the area participated and all the training was done in one hospital." In 1971, when Dr. Bucher became Dean, Mobile General was the only hospital in the city that offered a formal training program.

"And they never took people they didn't feel were qualified." There was a shortage of American medical graduates in the '70s, Dr. Bucher explained, and institutions all over the country were filling spots with foreign medical graduates. "This was never done at Mobile General. The quality at this hospital was consistently maintained. Training was never compromised for service needs." Dr. Bucher said he knew of no other area in the country where this existed.

"This school started faster than any other school in the country." Dr. Bucher, now professor of surgery, holds the distinction of being the first Dean of the College of Medicine at the University of South Alabama in addition to serving as professor of surgery, chairman of the Department of Surgery and Vice President for Health Affairs.

ROBERT M. BUCHER, M.D.

Dr. Robert M. Bucher holds the distinction of being the first Dean of the College of Medicine at the University of South Alabama. Dr. Bucher became Dean in 1971, professor of surgery in 1972 and Vice President for Health Affairs at U. S. A. in 1973. He served as chairman of the Department of Surgery for one year and is now professor of surgery at the University. Prior to his appointment in Mobile, Robert Bucher was Dean of Temple University School of Medicine in Philadelphia from 1958 to 1969.

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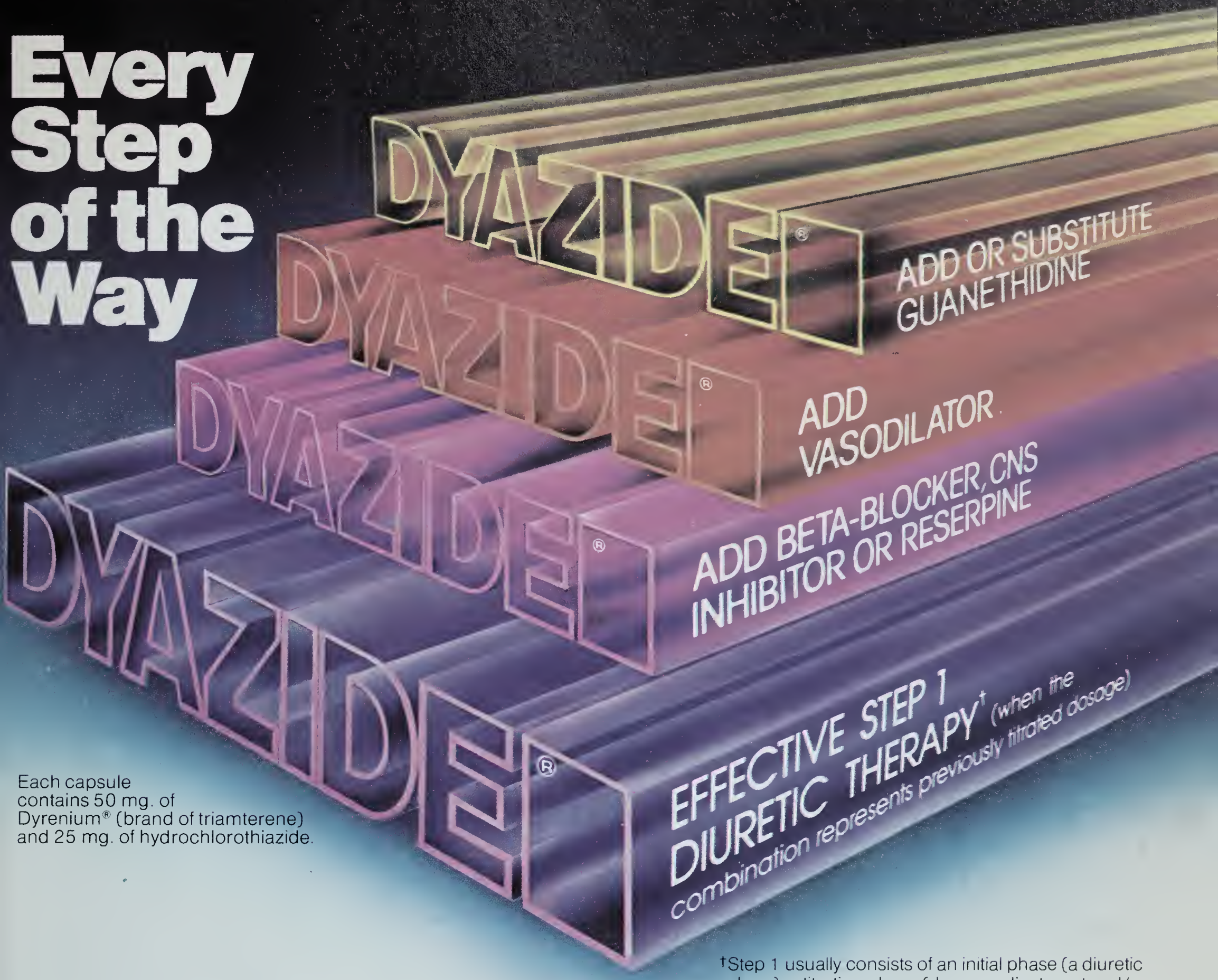

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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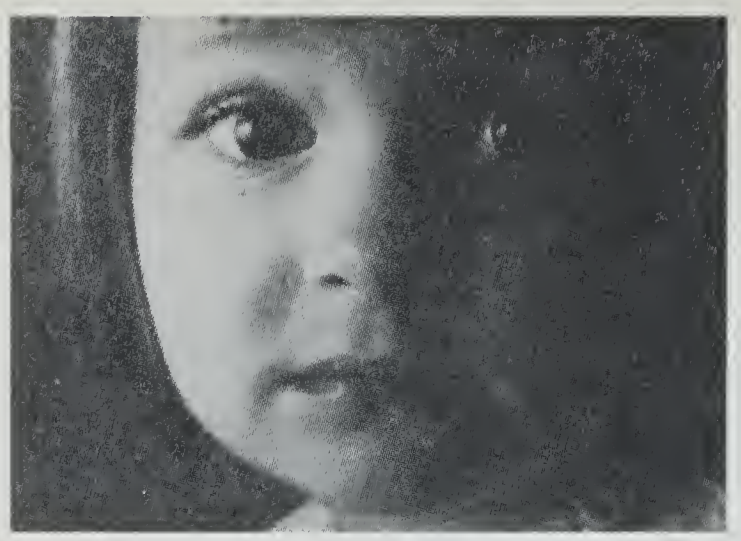

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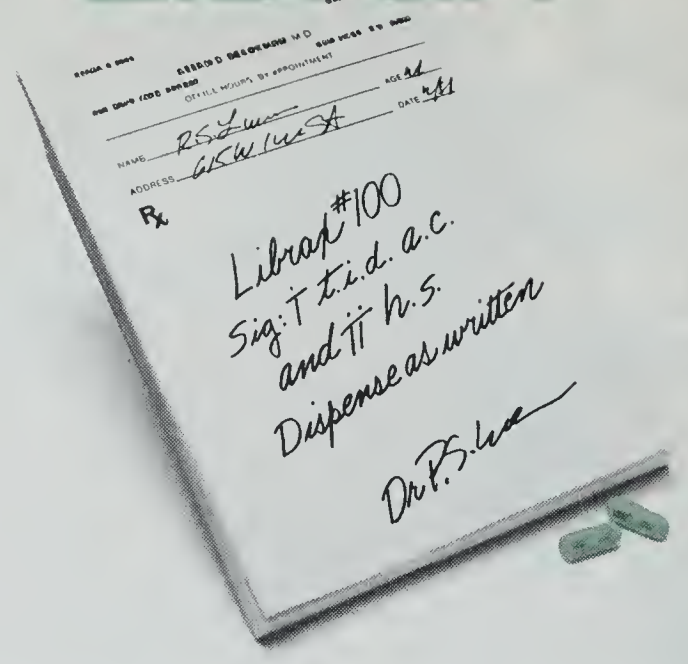

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered, isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Studies reveal an increased frequency of 3-cycles-per-minute slow wave basic electrical activity in the colons of patients with IBS—a significant difference in basic colonic rhythm patterns from normal subjects.[1,2] These findings suggest a physiological basis for the spasm and hypermotility characteristic of IBS. The role of severe anxiety in triggering or aggravating such symptoms has long been recognized. Consequently, treatment should focus on both aspects of the problem.

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References: 1. Sullivan MA, Cohen S, Snape WJ: *N Engl J Med* 298:878-883, Apr 20, 1978.
2. Snape WJ et al: *Gastroenterology* 72: 383-387, Mar 1977.

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Antianxiety/Antisecretory/Antispasmodic

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*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.

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getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

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(diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain dlagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation." [2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed , New York. Raven Press, 1978, pp. 391-404.

Tenuate® C IV
(diethylpropion hydrochloride USP)

Tenuate Dospan® C IV
(diethylpropion hydrochloride USP) controlled-release
AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personalty changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

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The Hospital was under the Daughters of Charity when Socrates "Soc" Rumpanos began his second year of internship in 1938. "There were only three of us. We had to see everything that came into the Hospital. We covered the emergency room, surgery, delivery and the clinics. Patients were a lot sicker then. They waited too long to come in. Ruptured appendix was the most common."

"Financially they made it attractive to stay in the hospital." Rumpanos, Woodrow Eddins and K. J. Compton were given room, board and laundry and a salary of $75 a month, of which $25 was held by the Chief until their terms were finished.

Although pressured to provide services, Rumpanos and his contemporaries recognized the importance of an approved graduate medical education program and worked toward this goal. "We did the work of ten men. We were real proud of getting accredited with only three of us."

In 1945, when Dr. Rumpanos returned from the Navy after World War II, the teaching program was more organized. "There were more interns and a residency program was starting." Dr. Rumpanos was later to serve as Chief of Staff at City Hospital.

SOCRATES NICHOLAS RUMPANOS, M.D.

Dr. Socrates "Soc" Rumpanos is a general surgeon practicing in Mobile. He served his second year of internship at the City Hospital of Mobile in 1938 and joined the clinical staff in 1940. When he returned from the Navy in 1945, Dr. Rumpanos joined the Hospital's surgical service. He served as Chief of Staff at the Hospital in the 1960s.

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"It was terrible to get a residency at the end of World War II." Dr. Benjamin B. Kimbrough Jr. recalls his experiences as an intern in 1941 and resident in 1946: "We were on call every other night. On two nights, off one. We only had three interns for 125 beds."

"We had the only emergency room in town. If I got four hours sleep, that was good." Dr. Kimbrough said the Hospital saw mostly charity cases. "We'd learn by reading, the staff would teach by doing. We just didn't have the facility for vascular surgery then. And we didn't have anesthesia as we know it today."

Sharing quarters in the Hospital with his friend and associate, Dr. Harry Webster, Kimbrough holds fond memories of the cramped hospital and the stern Sisters. "The Sisters could be hell, but they were nice to us." Dr. Kimbrough singled out Sister Gertrude for the eggnogs she would sneak him. "Interns couldn't date nurses, officially that is." Dr. Kimbrough got around that by dating a girl in the front office.

"There were no disposables. Rubber tubing had to be autoclaved. Now, we can do any type of surgery, there's no reaction, everything's completely sterile." Dr. Kimbrough feels medical practitioners have been fortunate in Mobile. "The doctors get along well."

BENJAMIN BURFORD KIMBROUGH JR., M.D.

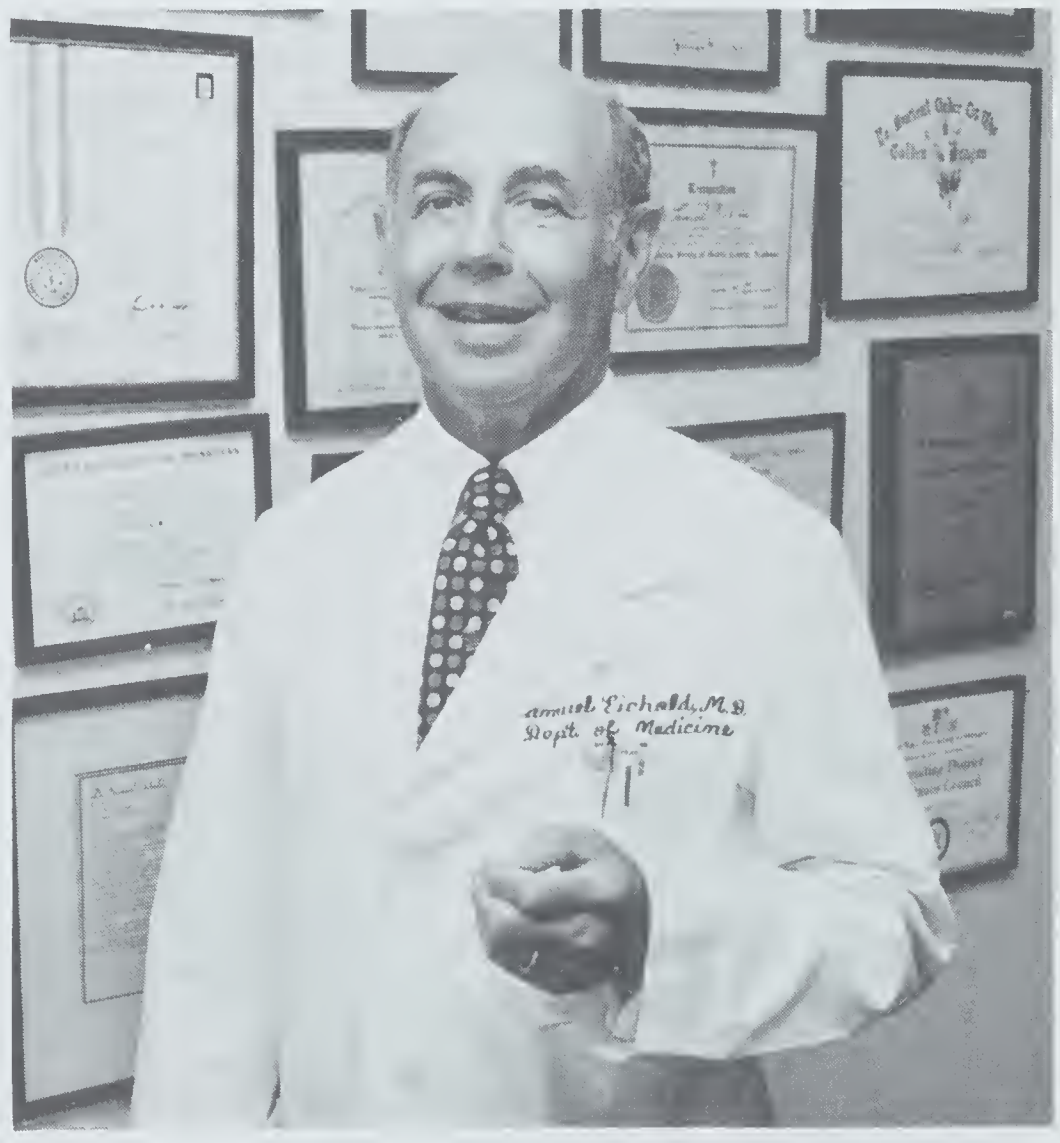
Dr. Ben Kimbrough is Medical Director at the Rotary Rehabilitation Division of Mobile Infirmary. He interned at the City Hospital of Mobile in 1941 and did a rotating residency in 1946. Dr. Kimbrough served the cities of Prichard and Chickasaw as a general practitioner from 1947 to 1967. He has been full-time director at Rotary Rehabilitation since 1977.

"Most of the Housestaff were not married and lived at the Hospital. Residents were paid $25 a month, interns were paid $15." Dr. Samuel Eichold was an internist in 1946 when he began teaching at the old Hospital. "There were about twelve internists in '46, each took about one month out of the year."

"Dr. Grady Segrest put it best. He said we got more out of it than we put into it." Dr. Eichold explained that residents were allowed to do what they wanted. "There were no formal lectures. Teaching was primarily bedside. The teaching staff had the responsibility to make rounds and be on call. Interns and residents had you to consult with. They were allowed to perform up to their abilities."

Sam Eichold taught in internal medicine and diabetes and started the first diabetic clinic in Mobile. In 1947 Dr. Eichold founded Camp Seale Harris for Diabetic Children and in 1981 he became the recipient of the Becton Dickinson Award for Contributions to Diabetes and Camping. He joined the faculty of the College of Medicine at the University of South Alabama in 1972.

"Graduate medical education was maintained in Mobile in spite of the lack of a formal school because of the concern and efforts of local physicians. The need was there and it was met." A professor in the Department of Medicine, Dr. Sam Eichold teaches a fourth-year class in the History of Medicine. He was honored in 1971 as the first recipient of the Community Service Award presented by the Medical Society of Mobile County. This award was presented to Dr. Eichold again in 1975.



SAMUEL EICHOLD II, M.D.

Dr. Sam Eichold, professor in the Department of Medicine at the University of South Alabama, is responsible for establishing the first outpatient diabetic clinci at the old Mobile City Hospital. He organized and directed the Continuing Medical Education program at U. S. A. and is a preceptor of the History of Medicine at the University. Dr. Eichold is the founder and curator of the Heustis Medical Museum, an extensive collection of medical instruments and artifacts, which is housed at the U. S. A. Medical Center.

"Mobile General Hospital was once called a 'tired old veteran of six wars' in an article appearing in the Mobile Press. This is true, but the hospital is a 'tired old veteran' of much more than six wars—it is a veteran of poverty, of floods, of fires, of epidemics, of pain and suffering,—of age, the worst of all.

"Soon, however, this tired old veteran will retire—with all honors possible for such long and faithful service to the citizens of Mobile and surrounding areas. This veteran will turn over its duties and responsibilities to the new, modern, the mechanized, the 'pushbutton' facility of the future.

"Although the doors will soon be closed for the first time since 1830 the old 'City Hospital,' 'County Hospital', or 'General Hospital'—whichever name is most familiar—will not be forgotten. As long as there is a Mobile, its citizens will recall and revere the memory of the ageless service to humanity provided by this tireless institution.[2]

The old Hospital was crumbling with age by 1960 when Drs. Ernest Brown and Edgar Fonde worked in pathology. "The autopsy room had a dirt floor and it was located close to the emergency entrance. The roof leaked, there were holes in the floors. I remember Dr. Fonde leaned against a wall and it fell through." But Ernest Brown said he always loved his work.

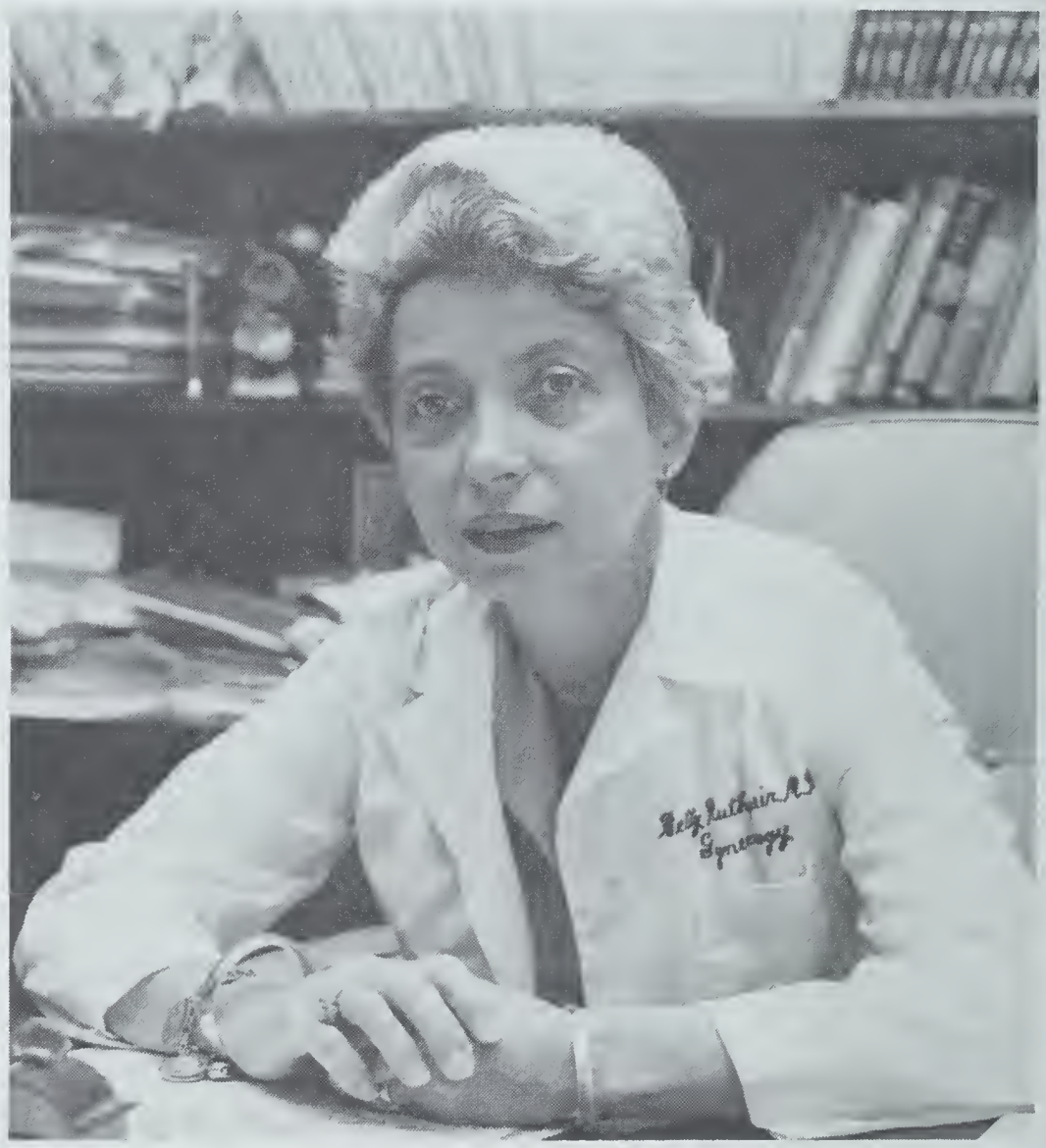
"There was a tremendous load of violent deaths because the coroner was at the Hospital. Dr. Earl Wert was the coroner. He was a major influence for me." Dr. Brown remembers a lot of camaraderie among the hospital staff. Teaching was informal. The hospital's small dining room, where family style meals were served, was a place for conversation.

"Manually you just couldn't do the work." Dr. Brown said he and Dr. Fonde purchased the first automated equipment for the laboratory. "We bought the equipment out of our own pockets and never charged the hospital for its use."

"Now it is really no different, just a better environment. Equipment changes have given us better answers." Dr. Ernest Brown did his residency at City Hospital in 1955, 56 and 57. He is now with Pathology Laboratory Associates, P. A., and is the director of the laboratory at Springhill Memorial Hospital in Mobile.

The first woman appointed to the clinical faculty in the U. S. A. College of Medicine was a resident at Mobile General in 1966 and 1967. "I started in the days when there was no third party money available. There were a lot more patients to care for. You did everything." Dr. Betty Ruth Speir had already been uprooted from her residency in Birmingham when her father died and she returned to Greenville to take over his practice.

ERNEST LADD BROWN, M.D.



BETTY RUTH SPEIR, M.D.

Dr. Ernest Brown, along with Dr. Edgar Fonde, purchased the first automated equipment for the laboratory at the Mobile General Hospital. Dr. Brown completed three years of residency in pathology at the old Hospital in 1957 and became a member of the staff in 1958. He is now with Pathology Laboratory Associates, P. A. and is the director of the laboratory at Springhill Memorial Hospital in Mobile.

Dr. Betty Ruth Speir was the first woman appointed to the faculty of the College of Medicine at the University of South Alabama. An OB/GYN resident at the Mobile General Hospital in 1966 and 1967, Dr. Speir delivered the first baby born at the new Mobile General. Becoming a full-time faculty member in 1975 and re-establishing her private practice in 1976, Dr. Speir maintains an active practice exclusively at the U. S. A. Medical Center.

Six months after beginning her residency at Mobile General the hospital moved to the new facility. "I delivered the first baby born at the new hospital." Dr. Speir recalls getting a severe strain doing deliveries at the new hospital because the tables were slightly higher.

"The teaching program is more rigid now. There are advantages and disadvantages. Knowledge is more accessible to residents. I regret the loss of the active participation of physicians in the area. They have so much to offer. Experience will always be the best teacher." Recalling her residency as an experience she wouldn't trade, Dr. Speir said her graduate training was never lacking. "The quality was great and the all-volunteer staff were exceptional. Dr. John Hope and Dr. O. M. Otts were heads of the OB program. We owe them a lot."

"The residents keep you on your toes," says Dr. Speir, who feels she receives more than she gives. Betty Ruth Speir went full-time with the medical school in 1975 and re-established her private practice in 1976. She is a member of the faculty of the U. S. A. College of Medicine and practices exclusively at the University of South Alabama Medical Center Hospital. "I've just never been weaned from U. S. A."

"When the school first started there were not enough physicians in the rural areas. Doctors had their practice in the city where most of the patients were." Dr. Irwin "Chip" Linton, chief medical resident at the University of South Alabama Medical Center, explained that in the late '60s and early '70s the thrust was to produce physicians to take care of rural populations. "The solution was not to provide more physicians, but to train more general practitioners."

The vital need for specialty care and accessibility have brought the trend around as Dr. Linton sees it. "It's critical to keep abreast of recent medical developments." And difficult even for the specialist, according to Linton, who said today there is actually every little call for a single, general physician who is responsible for a rural community.

Chip Linton will finish his residency in internal medicine in June. He said that he's found graduate training is harder for those who are in it for the wrong reasons. "It's not so much pressure if you're in it for the right reasons."

Choosing U. S. A. because the program is clinically oriented and he wanted to stay in the South, Dr. Linton says, "The clinical and academic program here is excellent. This program is oriented to produce practicing physicians for southern Alabama." According to Linton, between 50 and 60 per cent of U. S. A. residents stay in Alabama.

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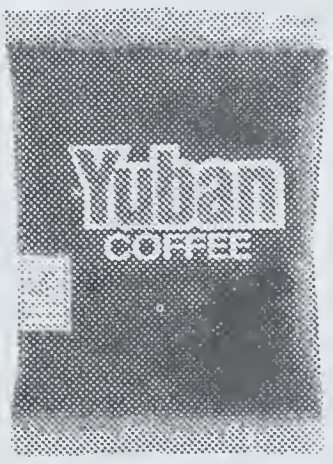

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With praise for the clinical faculty at the University of South Alabama, Dr. Linton said, "They have a good faculty here. Some are truly teachers who are motivated to pass on the knowledge their teachers gave them."

IRWIN GRIER LINTON, M.D.

Dr. Irwin "Chip" Linton is chief medical resident at the University of South Alabama Medical Center. He will complete his fourth year of residency in internal medicine in June, 1982 and plans to return to his hometown of Charleston, S. C. to establish his practice.

The Medical College of Alabama

Dr. Josiah Clark Nott was convinced of the many advantages that would result from the existence of a good medical school in Alabama and especially in Mobile. In 1858, he interested some of his friends and associates in the project, and as a result the citizens of Mobile subscribed $75,000 for the purchase of a museum and chemical apparatus.

The Medical College of Alabama was opened in a rented building on November 14, 1859. Since the facility was not suited for medical instruction, Dr. Nott sought aid from the Alabama Legislature. The Mobile Medical College was incorporated by an act of the Legislature in 1860 and the State appropriated $50,000 toward the purchase of land and construction of a building.

The Civil War and Alabama's secession from the Union led to the closing of the Medical College in 1861. The Medical College did not open again until 1868 when twenty-two students registered for study.

The Medical College of Alabama was constructed only a few blocks from City Hospital. The College and the Hospital were of great aid to each other, the free wards of the Hospital and the dispensary of the College were providing Mobilians the finest medical care available. Through the joint efforts of these two medical facilities, yellow fever was curtailed and cholera began to disappear from the Gulf Coast. The City Hospital

1830-1966

served as the primary teaching facility for the Medical College until 1920 when the College moved to Tuscaloosa.

Mobile General Hospital

By virtue of its history, the University of South Alabama Medical Center Hospital, which bore the name Mobile General Hospital, is one of the oldest hospitals in the nation.

The need for organized health care was seen as early as 1704 when Mobile was founded at 27 Mile Bluff. In 1711, when Mobile moved to its present location, a hospital was built and named "Hospital Royal."

During the Spanish rule of Mobile, 1781 to 1813, the facility was relocated and called "Kings Hospital" until 1819 when the city received its U. S. charter. The hospital name was changed to "City Hospital of Mobile" and it served the region until 1830.

In 1830 the corner stone was laid for a new City Hospital on property the city purchased for $150. When the building was partially completed in 1831, the City Hospital represented the finest architectural craftsmanship of its day. The Hospital served the Gulf Coast region for 136 years under many names; City Hospital, County Hospital, Port Hospital and Mobile General Hospital.

Today the renovated building is the home of the Department of Pensions and Security and is entered on the National Register of Historic Places. It stands as a monument to a continuous lineage of public health care and medical education.

Only two original hospital buildings remain in the United States, Pennsylvania Hospital in Philadelphia, the nation's oldest, and the Mobile General Hospital, the second oldest hospital in the country.

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[1] 1926, "Brief History of the Mobile City Hospital", author unknown. Acknowledgement for information from unpublished manuscript by Francois Ludger Diard.

[2] April 1961, The Tablet, Special 130th Anniversary Issue, "Ageless Servant of Humanity." Vol. 2, No. 12, April '61. Published by Mobile General Hospital, Mobile, Alabama. Tom Betancourt, Editor.

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FOREIGN BODIES OF GASTROINTESTINAL TRACT

by

T. Nagendran, M.D. and S. Nagendran, M.D.

INTRODUCTION

About 1,500 persons in the United States die from foreign body ingestion every year.[1] Intentional foreign body ingestion is common in psychiatric patients and in children and elderly who wear dentures. Our experience with eight patients in the past four years is presented. Literature is reviewed.

Case I

This 62-year-old, Black, male veteran was referred to our hospital with a 24-hour history of foreign body in the upper third of the esophagus. The afternoon before admission while eating chicken meat, he got choked at the upper third of the esophagus. The patient could feel the portion of the chicken meat in the back of his throat, but this could not be removed. Before admission to the hospital, a Barium Swallow was obtained, and the upper third of the esophageal obstruction was confirmed.

Soon after admission, the patient was examined on the ward with Cetacaine spray. The foreign body could be felt, but could not be removed. The patient was taken to the operating room and, under Innovar intravenous anesthesia, an attempt was made to dislodge the foreign body, but this could not be done. Therefore, the patient was anesthetized via endotracheal general anesthesia, and also received Valium intravenously. Subsequent to this, a Jackson esophagoscope was introduced and a portion of the foreign body was removed, but the rest of the foreign body slipped into the stomach. The patient recovered without any problem. The patient was edentulous, and he had no history of dysphagia before this episode.

Case II

This 45-year-old, Caucasian male was treated in March 1980 for Carcinoma of the Larynx. The patient underwent total laryngectomy. Subsequently, the patient developed dysphagia and Barium Swallow was obtained, which showed narrowing of the esophagus. Carcinoma of the esophagus was suspected. The patient was admitted to the hospital and placed on a liquid diet. On the second day of admission, the patient developed complete obstruction of the esophagus and regurgitated even liquids.

The patient was edentulous. An esophagoscopy was done and a large grape was removed from the stenotic area of the middle third of the esophagus. The patient was subsequently dilated, and Carcinoma of Esophagus was confirmed by biopsy.

Discussion[2,3,4,5]

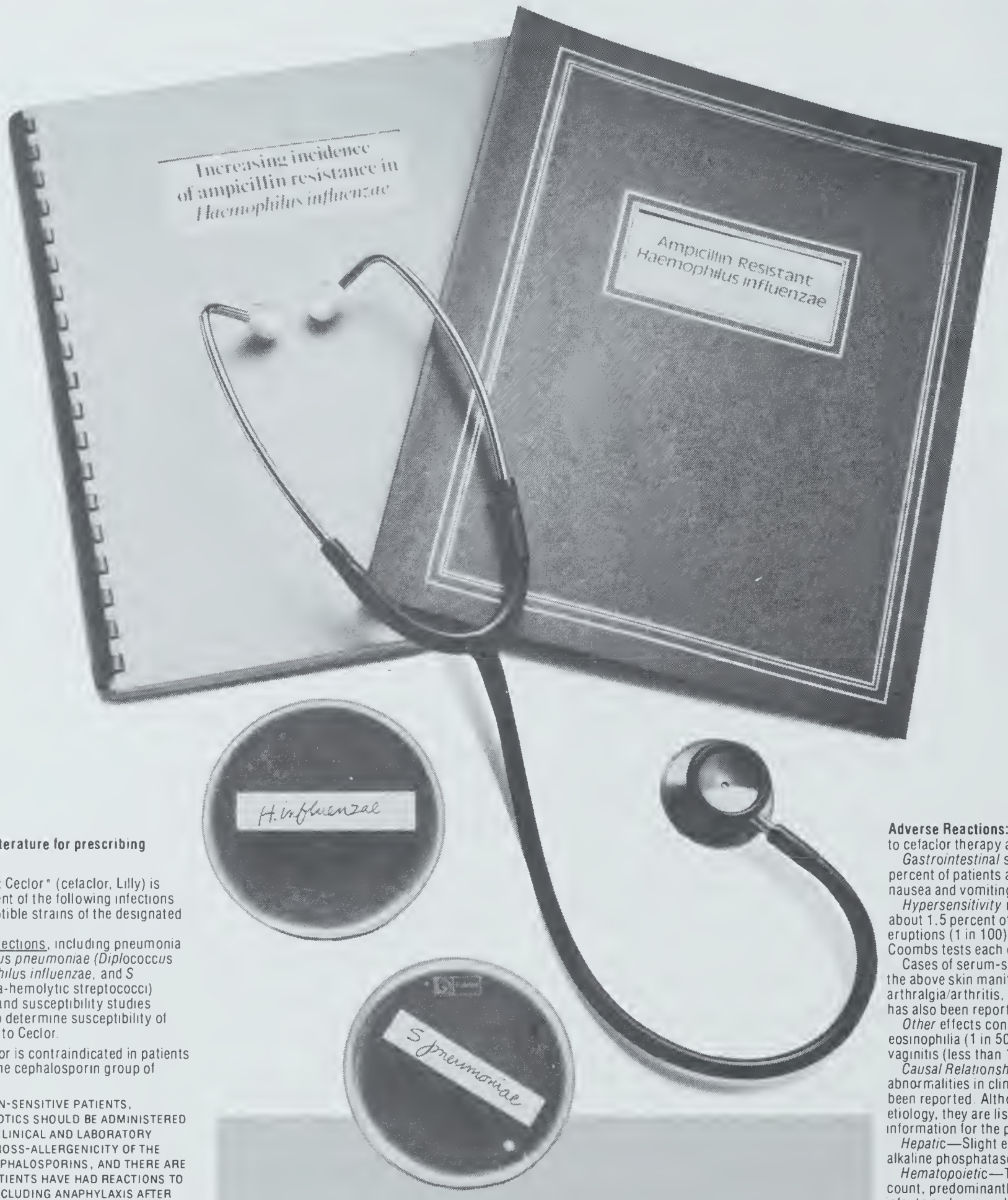
Cases I & II

Sixty to eighty per cent of swallowed objects pass through the gastrointestinal tract spontaneously and without significant sequalae. Twenty to thirty per cent of ingested bodies cause problems, usually in the esophagus. Impalament occurs either in the cricopharyngeus as in our first case or in the area of the left main stem bronchus and aortic arch crossing or in the diaphragmatic hiatus or in the area of benign or malignant stricture as in our second case. All foreign bodies of esophagus are surgical emergency because of potential aspiration.

The patients usually complain of pain, dysphagia or vomiting. X-rays of the neck, P.A. and Lateral views, and chest x-rays will help to locate the radiopaque objects. Flat thin objects, like coins, will lie in the coronal plane in the esophagus and in the sagital plane in the trachea. Gastrografin studies are needed to locate the non-opaque objects. Widening of the prevertebral space indicates edema or abscess.

All impaled sharp objects should be removed. Flexible endoscopy is safe and reliable and can be done without anesthesia. Children and uncooperative patients need general anesthesia. General anesthesia might relax the cricopharyngeus muscle and the foreign body might slip into the stomach as it happened in our first patient. This could have been avoided by placing the patient in Trendelenburg's position. Sometimes, the object might slip back into the nasopharynx. After removal of foreign bodies, the entire esophagus should be examined for possible lacerations, perforations or stric-

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [1030BOR]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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tures. Also, search must be made for pneumothorax mediastinitis and subcutaneous emphysema.

Perforations of cervical esophagus with abscess formation need drainage and broad spectrum antibiotics. Perforations into the chest will need drainage, total parenteral nutrition and gastrostomy.

Case III (X-ray #1)

This 26-year-old, Caucasian male veteran was admitted to the Psychiatric Service of this hospital for evaluation and management. While he was on the locked ward, the patient swallowed a broken fork and reported it to the nursing personnel. An x-ray of the abdomen was obtained but, due to poor technique, the foreign body was not found in the x-ray of the abdomen. The patient was returned to the Psychiatric Service.

On the third day after transfer, the patient complained that he had swallowed a piece of rod from the bed. This time, the x-ray revealed two foreign bodies in the stomach and the patient was seen by the Surgical Service. The patient had swallowed foreign bodies approximately seven times in the past three years, and these were removed by four different abdominal explorations and twice through the endoscope. The patient underwent exploratory laparotomy. Due to multiple previous operations through the midline, the abdominal cavity could not be entered. So, a second transverse incision was made in the left upper quadrant and the stomach was exposed and the foreign bodies removed. The patient's postoperative period was benign. He underwent psychiatric treatment and he was discharged from this hospital.

X-Ray I.

X-Ray II.

Case IV (X-ray #2)

This 61-year-old, Caucasian male, psychiatric patient who attempted to kill himself on many different occasions complained of abdominal pain. X-ray of the abdomen revealed multiple foreign bodies in the G.I. tract. Most of them were coins and checkers. The patient was treated in the Surgical service conservatively with bulk laxative and high residue diet. The patient passed all of the foreign bodies without any difficulty.

X-Ray III.

Case V (X-ray #3)

This 65-year-old, Black, male, psychiatric patient complained of abdominal pain. Examination of the abdomen was negative. A Flat film of the abdomen showed multiple coins. The patient was treated conservatively. He passed all of the coins without any problems.

Discussion[4]

Cases III, IV & V

Those objects which pass through the pylorus, usually pass through the rest of the intestinal tract without any problem. A high fiber diet will aid in smooth passage of objects. Following are indications for celiotomy: a) suspected perforation; b) intestinal obstruction; c) failure of objects to pass; d) associated bleeding; and, e) failure of endoscopic removal. Preoperative x-ray is always made immediately prior to celiotomy.

Case VI

This 50-year-old, Caucasian, male veteran was referred to us with a diagnosis of Bezoars in the stomach. The patient gave a history of partial gastrectomy for duodenal ulcer disease, done 17 years prior to this admission. An endoscopy was not done. The patient underwent exploratory celiotomy and a large ball of animal meat fibers was removed from the fundus of the stomach. The patient's postoperative period was benign.

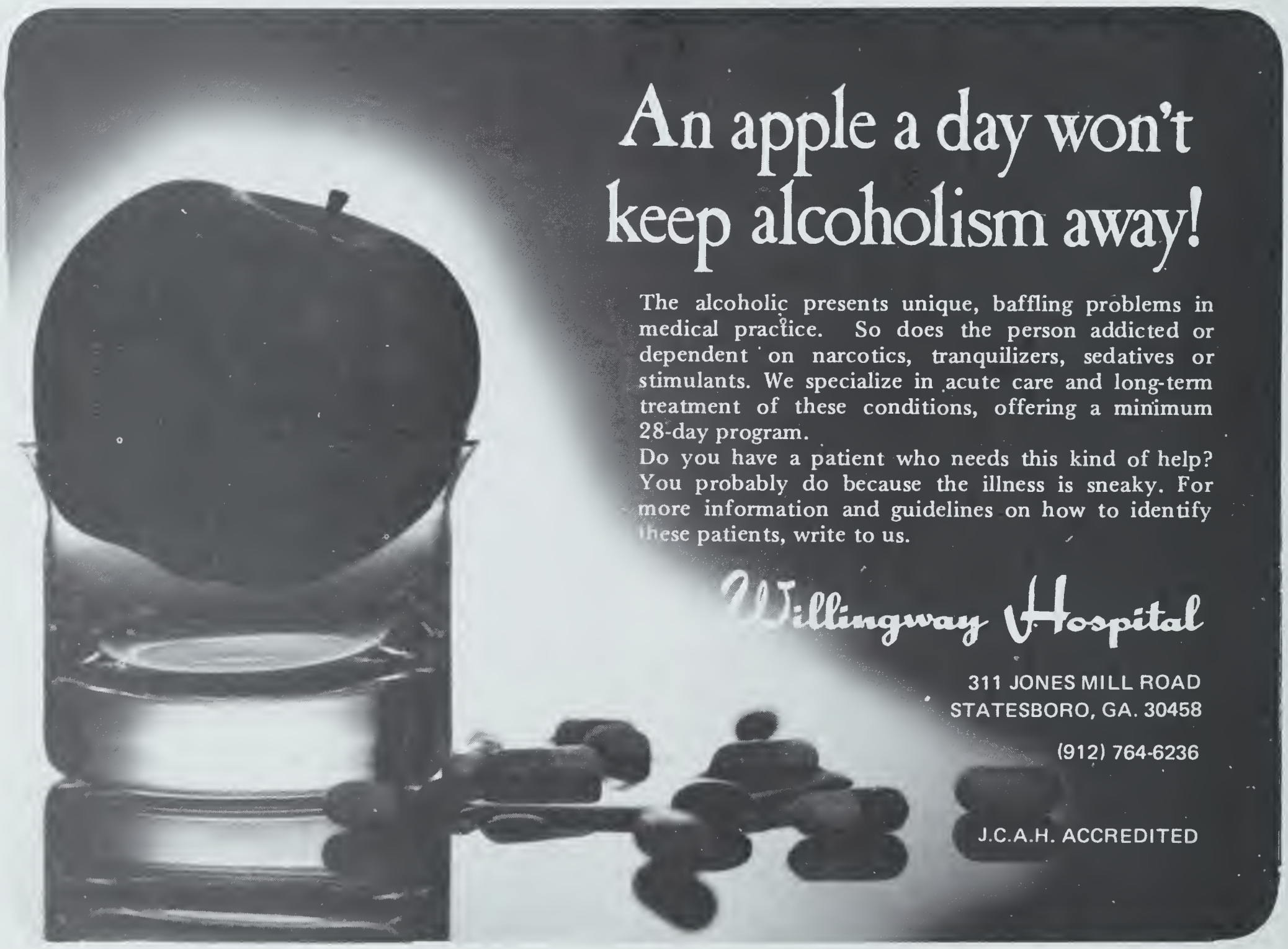
Discussion[6,10]

Case IV

Bezoars are concretions formed by the swallowing of material retained in the stomach. Four kinds are found: 1) Tricho Bezoars (hair)—55%; 2) Photo Bezoars (vegetable fibers); 3) Trichophyto Bezoars; and, 4) Concretions. Reduced acidity and motility, like in duodenal ulcer, surgical procedures seem to predispose to bezoars as demonstrated in our case. Anoxeria, nausea, vomiting, abdominal pain and palpable mass are common symptoms and signs. Surgical removal should be carried out if intragastric administration of cellulose preparation should fial to loosen up bezoars.

Case VII

This 57-year-old, Black, male veteran was admitted to Tuskegee VA Medical Center with an 18-hour history of right lower quadrant pain and nausea. The patient was noted to have a temperature of 100 with marked tenderness in the right lower quadrant, along with rebound tenderness. The plane x-rays of the abdomen were



unremarkable. His W.B.C. count was 13,000, with shift to the left. The initial impression was perforated acute appendicitis. The patient underwent exploratory laparotomy and was found to have perforation of the ileum, approximately a foot from the ileocecal valve. The perforation was caused by a fish bone measuring 2.5 cms. long and 0.3 cm. wide. The perforation was found close to the mesenteric border, and there was localized suppuration. A portion of the fish bone was still inside the ileum. The fish bone was removed, and ileum was sutured. The postoperative period was uneventful. In the postoperative period, the patient admitted eating fish 24 hours prior to the onset of the symptoms.

Discussion[7]

Case VII

The common foreign bodies which cause perforation are: a) toothpick; b) pins; c) wires; d) chicken bones; e) fish bones, and, f) wooden splinters. Seventy-three per cent of perforations occur in and around the ileocecal region. Perforations of bowel result in either localized peritonitis as in our case or generalized peritonitis. Diverting colostomy is considered in left-sided colonic perforations with much fecal spillage.

Case VIII

This middle-aged, Caucasian, male veteran who had been treated in this hospital for psychiatric illness for the past many years, introduced a baby food jar into the rectum. This was noted by the nursing personnel and the patient was brought to the Surgical Clinic. With a large amount of K-Y Jelly lubrication, the glass jar was removed. After the removal, the rectum was carefully examined. The anal sphincter was intact and there was no evidence of laceration or perforation. There was no complication following the retrieval of the foreign body. The mouth of the jar was pointing towards the anus.

Discussion

Case VIII

The majority of objects are inserted into the rectum for erotic sexual stimulation. This is more common in males. The exact incidence is not known. Patients usually seek medical help for one of two reasons: a) unable to remove the object; and, b) rectosigmoid perforation.

Diagnostic procedures should include complete abdominal examination, bi-manual rectal examination, proctosigmoidoscopy and bi-plane abdominal x-rays.

Treatment is dependent upon: a) location, shape, number, composition and duration of presence of objects. The majority of them can be removed in the clinic without anesthesia, like in our case. Low-lying objects are removed manually and high-lying objects need spinal anesthesia and proctoscopic removal. High-lying impacted objects are removed via celiotomy and either transanal manipulation or colostomy.

Perforations above peritonial reflections are dealt with closure of perforations and diverting colostomy. Below the peritonial line perforations need presacral drainage, diverting colostomy, repair of perforations if feasible and antibiotics.

After removal of foreign bodies, rectum should be examined for lacerations. Also, workup should be done to rule out Gonorrhea and Syphilis.

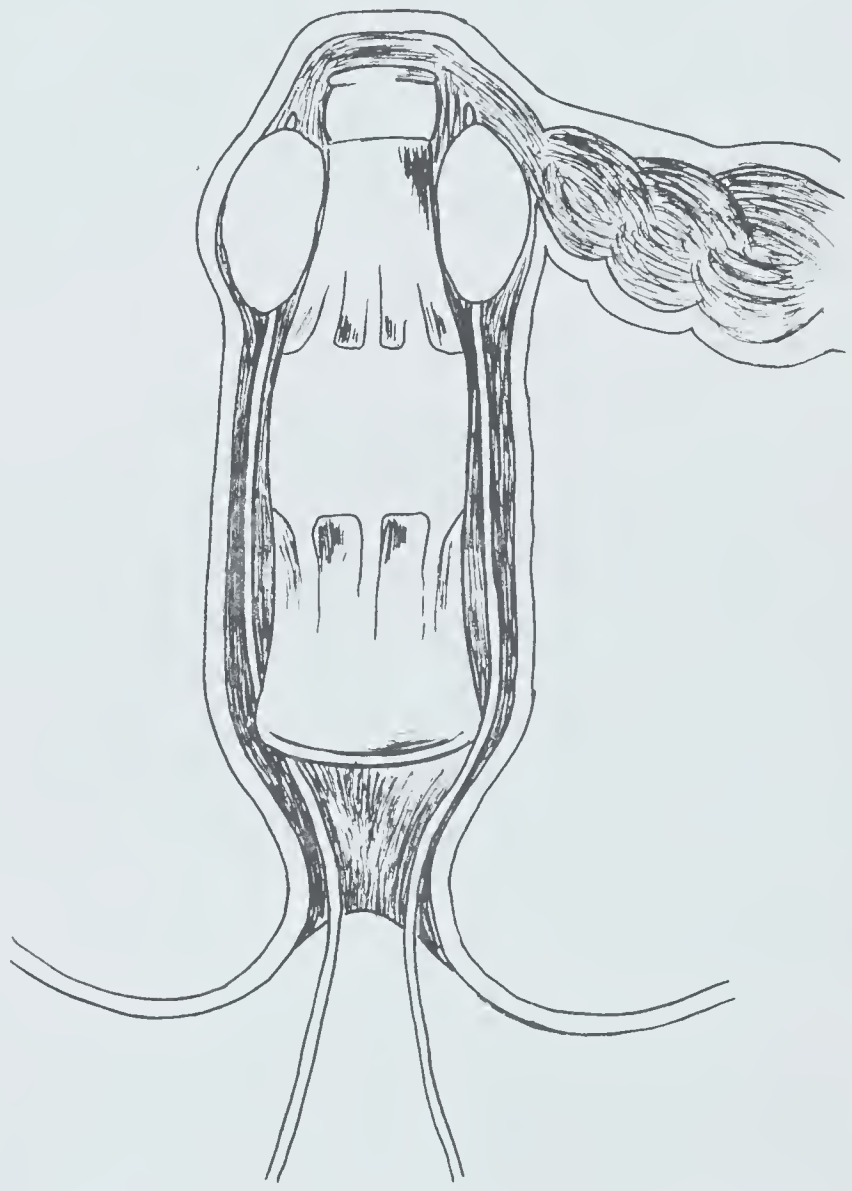


Fig. 1. Hollow objects like bottles facing cephalad in the rectum present a special problem because of the suction effect it produces on the mucosa. Removal is facilitated by inserting two or more foley catheters along the side of bottle and inflating baloons.

Conclusion

Foreign bodies of gastrointestinal tract presents many different challenging problems. Eight such cases have been presented. Literature is reviewed.

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ABDOMINAL AORTIC ANEURYSMS SIMULATING UROLOGIC DISORDERS

by
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ABSTRACT

Three cases of abdominal aortic aneurysms (AAA) simulating urologic disorders are presented. Diagnosis was made from the calcifications seen on the IVP in two patients and by cystoscopy in the third case. A brief summary of the bizarre urologic signs and symptoms is presented to help in the early diagnosis of this tricky disease.

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INTRODUCTION

Abdominal aortic aneurysm (AAA) is more common in males in the upper portion of the abdominal aorta and is usually of the saccular variety. Atherosclerosis is the most common cause of spontaneous (AAA)[21]. Ruptured (AAA) generally presents as an acute and rapidly fatal disease, if not diagnosed and treated immediately. However, about 10% of all aortic dissections are chronic, i.e. the patient survives more than 4-6 weeks[14,15,21]. AAA may simulate gastrointestinal[5,6,9], neurologic[4,6,17] disorders, and even splenic rupture[6]. It is not infrequent for AAA to simulate genitourologic disorders[1,2,3,8,10,12,13,14,18, 19, 21]

(AAA) simulating genitourologic disorders initially were reported to be 10% in 400 cases by Culp[10], one out of two in 27 cases reported by Friedenberg[18], and 9 out of 65 cases reported by Burke[2].

Case I *(PROSTATISM)*

A 69 year old white male patient, hypertensive and diabetic on 36 units of NPH daily, was admitted to Carraway Methodist Medical Center because of suprapubic pain and "burning sensation" in the suprapubic area, increased urinary frequency day and night, urgency, partial pain relief after voiding. No history of hematuria. He was treated at another institution for the same symptoms with Geocillin and Percodan one month prior to admission without improvement. Past history revealed a rectal abscess which was drained nine months prior to admission.

The patient did not appear acutely ill, was normotensive and afebrile. He weighed 125 kgs. No cardiorespiratory findings. The abdomen was protuberant with tenderness and muscle guarding in the suprapubic area. No thrill or pulsatile mass could be felt. Genitalia were normal. The prostate was tender and slightly enlarged.

Urinalysis revealed microscopic hematuria. Urine culture was negative. Blood chemistry profile was normal, except for blood sugar 190 mg.%. Renal profile was normal. VDRL negative. Cystoscopy was done the following day, and it showed no prostatic obstruction, but it revealed a pulsatile bladder wall. Filling the bladder with saline reproduced his pain which was relieved by emptying.

An infusion IVP was scheduled after cystoscopy. We consulted the vascular surgeon immediately. An aortogram showed abdominal aortic aneurysm and a saccular aneurysm protruding into the pelvis (Fig. 1). The patient was explored the same day. Abdominal examination under anesthesia disclosed a pulsating mass below the umbilicus. A ruptured (AAA) protruding into the pelvis was found and a synthetic graft was placed. His postoperative course was uneventful, and his symptoms were completely relieved.

Case 2 (Prostatism) L.A., 59 years of age, admitted to CMMC because of low backache, dysuria, increased urinary frequency and nocturia. He was treated with different antibiotics for chronic prostatitis in the last two months prior to admission without improvement. He also complained of "burning up inside me," constipation and indigestion. History of hypertension, otherwise he had always been healthy.

Physical examination revealed an obese patient. BP 110/72; pulse 76; afebrile in no acute distress. Chest, abdomen and genitalia were all normal. There was minimal prostatic enlargement. Urinalysis, culture and sensitivity were normal. CBC, renal profile, SMA-12 all were

normal. VDRL was not reactive. Cystoscopy showed no sign of obstruction. Excretory pyelogram was normal except for calcifications in the mid abdomen in the left side. Accordingly an abdominal sonography was done and revealed the presence of 5.5 cm. AAA which was confirmed by an aortogram. Fig. 2 (A,B). The aneurysm was resected and with placement of dacron graft. The patient recovered after a stormy postoperative period because of a pulmonary embolus.

Case 3 (Renal Colic). C.H., 56 years of age, was transferred to CMMC for evaluation and treatment of a possible right ureteral calculus. The patient had an abrupt onset of sharp pain in right flank, radiating to the right groin. This was associated with nausea, vomiting, dysuria and microscopic hematuria. An excretory urogram was sent with the patient. It was normal except for calcifications in the mid abdomen. Fig. 3 (A,B.). Past history revealed that he was hypertensive, and he had thrombophlebitis three years ago and was placed on Coumadin 5 mg. daily since then. He passed several renal calculi and had an upper gastrointestinal bleeding two years ago.

Physical examination revealed an obese patient in acute distress because of the abdominal pain. BP 106/76; pulse 108 and afebrile. Chest examination was normal, but the abdomen was distended, tender, with no bowel sounds and no masses nor bruit. Genitalia and prostate were normal. A weak left femoral pulse and an absent right femoral pulse. Within half an hour his general condition deteriorated and went in shock. His hematocrit was 31% on arrival. He was transfused with blood and fresh plasma and given vitamin K immediately. Shock due to massive internal bleeding precluded the usual diagnostic workup. An immediate vascular surgery consult was obtained. He was explored after his general condition was stabilized, and a large (AAA) was found leaking from the right inferior margin. The patient had a cardiac arrest on the table and died in spite of the extensive resuscitation. Lab data showed a nonreactive VDRL, PT 20.5; control 12.8, normal renal profile, negative urine culture with microscopic hematuria.

DISCUSSION

The clinical diagnosis of abdominal aortic aneurysm (AAA) is sometimes overlooked. As a rule AAA cannot be palpated through the average abdominal wall,[14,21] because the tenderness over the mass and the rigidity of the abdominal wall are frequent findings. The patient with ruptured (AAA) may deteriorate rapidly, therefore the urologist who might see such a patient with urologic disorders should be aware of the bizarre signs and symptoms.

Continued on page 41

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THERE AIN'T NO FREE LUNCH

Continued from page 9

specific providers and only with that group of limited providers.

Somehow or the other these comments do not particularly reassure me about Mr. Reagan's intentions to get the government off our back. And, quite frankly, it is very understandable that that is not going to occur. We are going to spend almost $250 billion on health care this year. About 42% of it is going to be spent by government. There is no way that you are going to get that kind of money without some form of regulation.

There is no way that the bureaucracy is going to withdraw itself from the control of those kinds of dollars. There ain't no free lunch according to Milton Friedman and he is so right. Those groups that insist upon standing to feed at the federal trough must expect to dance to the federal tune and those who dance to the federal tune must expect to pay the federal price.

I believe that it is damn well time that we in the medical profession begin to communicate with the public, our patients, our increasing concerns regarding the health care system of this country. Like us or not, I think that even our most strident critics must admit that we are delivering more and better health care to more individuals than at any other time in the history of this world. Furthermore, given unlimited resources there is an even greater volume of health care, technology and improved health available for more people than at any other time in history. But somehow the message is not being spoken, or is falling on deaf ears.

President Lincoln once said, "In this and like communities, public sentiment is everything. With public sentiment nothing can fail; without it nothing can succeed. Consequently he who molds public sentiment, goes deeper than he who enacts statutes or pronounces decisions He makes statutes and decisions possible or impossible to be executed." As physicians you and I no longer have the privilege of non-participation. We must provide in-put into the decision making process. We must be proactive and assertive, not reactive and dissident.

The times they are a changing. Regardless of whether or not we have in-put into the new health care system that is going to be developed, you and I will be charged with the responsibility of its delivery in whatever shape, form or fashion it occurs. If we do not make our positions known we will have no impact. We shall be swept into the rubble of the new system and damned for its every failure. I for one do not intend to take it lying down. How about you?

J. Kendall Black, Jr., M.D.

CYCLAPEN®-W (cyclacillin)

Indications
Cyclocillin hos less in vitro octivity thon other drugs in the ampicillin closs ond its use should be confined to these indicotions: Treotment of the following infections:
RESPIRATORY TRACT
Tonsillitis ond phoryngitis coused by Group A beto-hemolytic streptococci
Bronchitis ond pneumonio coused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis medio coused by *S. pneumonioe* (formerly *D. pneumaniae*) ond *H. influenzoe*
Acute exacerbotion of chronic bronchitis coused by *H. influenzae**
*Though clinicol improvement hos been shown, bocteriologic cures cannot be expected in oll potients with chronic respirotory diseose due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentory) infections coused by Group A beta-hemolytic streptococci ond stophylococci, nonpenicillinose producers.
URINARY TRACT INFECTIONS coused by *E. coli* ond *P. mirabilis*. (This drug should not be used in ony *E. coli* ond *P. mirobilis* infections other thon urinory troct.)
NOTE: Perform cultures ond susceptibility tests initiolly ond during treotment to monitor effectiveness of theropy and susceptibility of bocterio. Theropy moy be instituted prior to results of sensitivity testing.
Contraindications Controindicoted in individuols with history of an ollergic reoction to penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use of ontibiotics moy promote overgrowth of nonsusceptible organisms. If superinfection occurs, toke oppropriote meosures.
PREGNANCY: Pregnoncy Cotegory B. Reproduction studies performed in mice ond rots ot doses up to 10 times the humon dose reveoled no evidence of impoired fertility or harm to the fetus due to cyclocillin. There ore, however, no odequote ond well-controlled studies in pregnant women. Becouse onimol reproduction studies ore not olways predictive of humon response, use this drug during pregnoncy only if cleorly needed.
NURSING MOTHERS: It is not known whether this drug is excreted in humon milk. Becouse many drugs ore, exercise coution when cyclocillin is given to o nursing womon.
Adverse Reactions Orol cyclocillin is generolly well toleroted. As with other penicillins, untoword sensitivity reoctions are likely, particularly in those who previously demonstroted penicillin hypersensitivity or with history of allergy, osthmo, hoy fever, or urticorio. Adverse reoctions reported with cyclocillin: diarrheo (in approximotely 1 out of 20 potients treoted), nouseo ond vomiting (in opproximotely 1 in 50), ond skin rash (in opproximotely 1 in 60). Isoloted instonces of headache, dizziness, obdominal pain, voginitis, ond urticoria hove been reported. (See WARNINGS) Other less frequent adverse reoctions which moy occur ond ore reported with other penicillins ore anemio, thrombocytopenio, thrombocytopenic purpuro, leukopenio, neutropenio ond eosinophilia. These reoctions ore usuolly reversible on discontinuotion of theropy.
As with other semisynthetic penicillins, SGOT elevotions hove been reported.
As with ontibiotic theropy generolly, continue treotment ot leost 48 to 72 hours after potient becomes osymptomotic or until bocterial eradication is evidenced. In Group A beta-hemolytic streptococcol infections, at least 10 doys' treotment is recommended to guord ogoinst risk of rheumotic fever or glomerulonephritis. In chronic urinary troct infection, frequent bacteriologic ond clinicol opproisol is necessory during therapy ond possibly for severol months ofter. Persistent infection moy require treatment for severol weeks.
Cyclacillin is not indicoted in children under 2 months of oge.
Patients with Renol Foilure Cyclocillin moy be safely odministered to patients with reduced renal function. Due to prolonged serum half-life, potients with vorious degrees of renal impoirment moy require chonge in dosage level (see DOSAGE AND ADMINISTRATION in pockage insert).
Dosage (Give in equolly spoced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract Tonsillitis & Phoryngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis ond Pneumonio		
Mild or Maderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chranic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Urinory Tract	500 mg q.i.d.	100 mg/kg/day

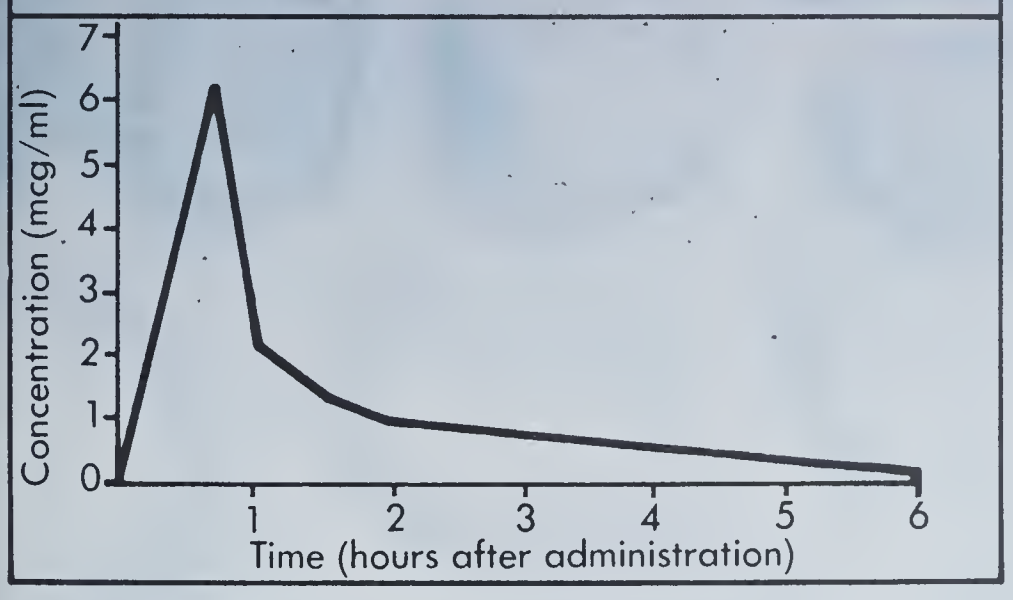
*Dasage shauld not result in o dose higher thon thot for odults.
†depending on severity

Wyeth Laboratories
Philadelphia, Pa. 19101

Half the dose is absorbed in 9 minutes!

compared to 32 minutes for ampicillin.*

Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T^{a} ½ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See **important information on facing page.**

CYCLAPEN®-W
(cyclacillin)

250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW NAME

Mrs. Rufus E. Lee, Jr.
President, A-MASA

OUR PUBLIC IMAGE

"I like my doctor okay but most of them are just interested in money."

"My doctor was in the room with me no more than 3 minutes and he charged me $50."

"Dr. Smith has a lovely expensive home but he can afford it with the prices he charges."

"That beautiful new Mercedes belongs to my doctor's wife. I paid for it with Johnnie's appendix. I bought her an emerald ring last year when Laura broke her leg."

That, my friends, are the examples of the public image most of us possess. It makes us feel unloved and guilty even though I know so much more about the true image of the physician than the people who make those remarks.

Yes, we have more luxuries than the majority of the people but there's no way for them to know the true cost of those luxuries. How can anyone outside of medicine know how hard the physician works, how much stress he is under, and the personal sacrifices made by him and his family. They can't know how he worries when someone doesn't get better according to schedule and how he grieves when a patient dies.

Why can't my friends see these qualities too without my having to tell them? My grandmother used to tell me, "If you do something worthwhile, you won't have to tell anyone. They will know." I still believe that's true to a degree but also believe we need to begin a little public relations business. The patients or public will trust their physician more if they know his heart is not made of stone.

There are a number of Alabama physicians who have taken their vacation time or time away from their practice to go to Africa at their own expense to help teach doctors and nurses their surgery and medical techniques, to take supplies, and to operate on and treat the people. There are many doctors who give their time at free clinics, at seminars and to many charity benefits. You think, "I don't want any publicity for that." Also, the medical profession already enjoys a better reputation than most other professions.

Times are changing and everyone (not only children) need role models. We, as medical families, are role models whether we like it or not. Most of the time the image is excellent but it seems the media always accentuates negatives. Bad news sells better than good news. There is a difference between public awareness and self seeking publicity.

Sir William Osler has said:

"In the life of every successful physician there comes the temptation to toy with the Delilah of the press—daily and otherwise. There are times when she may be courted with satisfaction, but beware! Sooner or later she is sure to play the harlot, and has left many a man shorn of his strength, namely the confidence of his professional brethren."

No, physicians themselves do not need to court Delilah. Let us, the Auxiliary, do it for you.

Our plans for this year include working on public relations and one of the areas we plan to take is radio interviews. The Auxiliary members will interview the doctor from a pre-arranged script, she will tape it, and it will go on Public Service time.

If you are invited to be interviewed, please don't turn it down. It is an avenue hat is very informative to your patients and an excellent public relations tool for the medical profession. Each interview should take only 5 minutes. One advantage of doing this is we can listen to the tape and if it doesn't sound exactly right we can start over.

Of course, we try to gear all our projects toward better health in Alabama and better Public Relations. Some of these include health fairs, worry clinics, immunization programs, health education workshops, fun runs and nutrition classes.

This past week in Chicago, AMA Auxiliary Presidents elect attended a Leadership Confluence designed to enable us to better achieve our goals.

We had lecturers from across the nation who are experts in their fields speak to us on "Public Relations," "All You Need To Know About Being A Leader," "The Aging Population," "The Family of the Impaired Physician," "Substance Abuse," "Home and Street Safety," "Life Stress Management," "Parenting A Teenager," "Legislation" and many others.

Thank you for allowing us, your auxiliary arm, to educate ourselves so that we can assist you in promoting better health.

Mary Julia Lee

ABDOMINAL AORTIC ANEURYSMS SIMULATING UROLOGIC DISORDERS

Continued from page 37

A. **Upper urinary tract symptoms:**[2,5,7,8,10,13,14,18,19,21]

1. Pain: Is the most dominant urologic symptoms. It is usually sharp simulating renal colic and might be dull and boring. It is usually of sudden onset, originates from the left flank or the lower part of the abdomen, radiates to the testis, thigh, hip and even down to the foot, but it may be bilateral. One of our patients presenteded with right renal colic.

   It may be segmental, manifested as skin hyperesthesia[21]. It is often intermittent, but may be constant. It is influenced by postural changes and usually fails to respond to opiates. Such abdominal pain in an old patient with normal upper collecting system is suggestive of (AAA).

   Pinck[14] reported eleven patients with such abdominal pain; Burke[2] reported four cases.
2. **Renal:** As perinephric abscess[19,20], perirenal hematoma, hydronephrosis, renal neoplasm, or renal calculi of various types. Pinck reported a case that manifested like renal tumor.

   Rupture of the aneurysm may lead to a large accumulation of blood in the retroperitoneal space or in the perirenal fossa, simulating a perinephric abscess or a renal tumor[21].
3. Oliguria, anuria and azotemia:[7, 8, 10, 11, 13, 14, 18, 19, 21]

   These are either due to renal infarction to compromised blood supply due to the dissection of the aneurysm, thrombus, embolus, or mechanical occlusion of the renal vessels, blood loss and overt shock, or due to retroperitoneal fibrosis associated with (AAA).

   Pahira[8] reviewed sixteen cases of bilateral ureteral obstruction secondary to AAA, half of which were azotemic, oliguric or anuric.
4. Ureteral occlusion:[1,7,8,10,11,13,16]

   Due to encasement of the ureters in the perianeurysmal fibrous tissue, which was reported to be diagnosed by ultrasonography and CAT scan.
5. Hematuria: May be microscopic or gross. Is usually due to infarction of the renal parenchyma. Pinck[14] reported a case of AAA whose only symptom was total painless hematuria. Graham[3] reported a case with rupture AAA into the retroaortic renal vein, presented with hematuria.

B. **Lower urinary tract symptoms**

1. Prostatism: Burke[2] reported 5 cases of AAA presented as prostatism, Uhle[14] as well reported one case. We had 2 patients with prostatism, one was diagnosed by cystoscopy.
2. Bladder outlet obstruction:[11,14,17] was reported due to hypogastric artery aneurysm.
3. Testicular pain: Usually it is a referred pain, but Pinck[14] reported a 64 year old patient with AAA whose only complaint was left testicular pain.
4. Perineal pain, dysuria, increased frequency and urgency of urination.[17,18].
5. Pulsating urinary stream[10]: The most unusual symptom synchronous with the patient's pulse.
6. Sexual disturbance[10,13]: As loss of libido or potentia.
7. Genital ecchymosis[10]: Manifests at the base of the penis in absence of trauma because the blood extravasates like urine.

Fig. 1. Aortogram shows abdominal aortic aneurysm dissecting into the pelvis.

Fig. 2. (a) Normal excretory urogram with calcification in the mid abdomen in left side suggestive of abdominal aortic aneurysm. (b) Aortogram shows the abdominal aortic aneurysm.

Fig. 3. (a) Excretory urogram left oblique view show mal rotation of the renal pelvis and calcification medial to the left ureter suggestive of abdominal aortic aneurysm.

Fig. 3. (b) Right oblique view of excretory urogram shows a normal right collecting system with calcification suggestive of abdominal aortic aneurysm.

SUMMARY

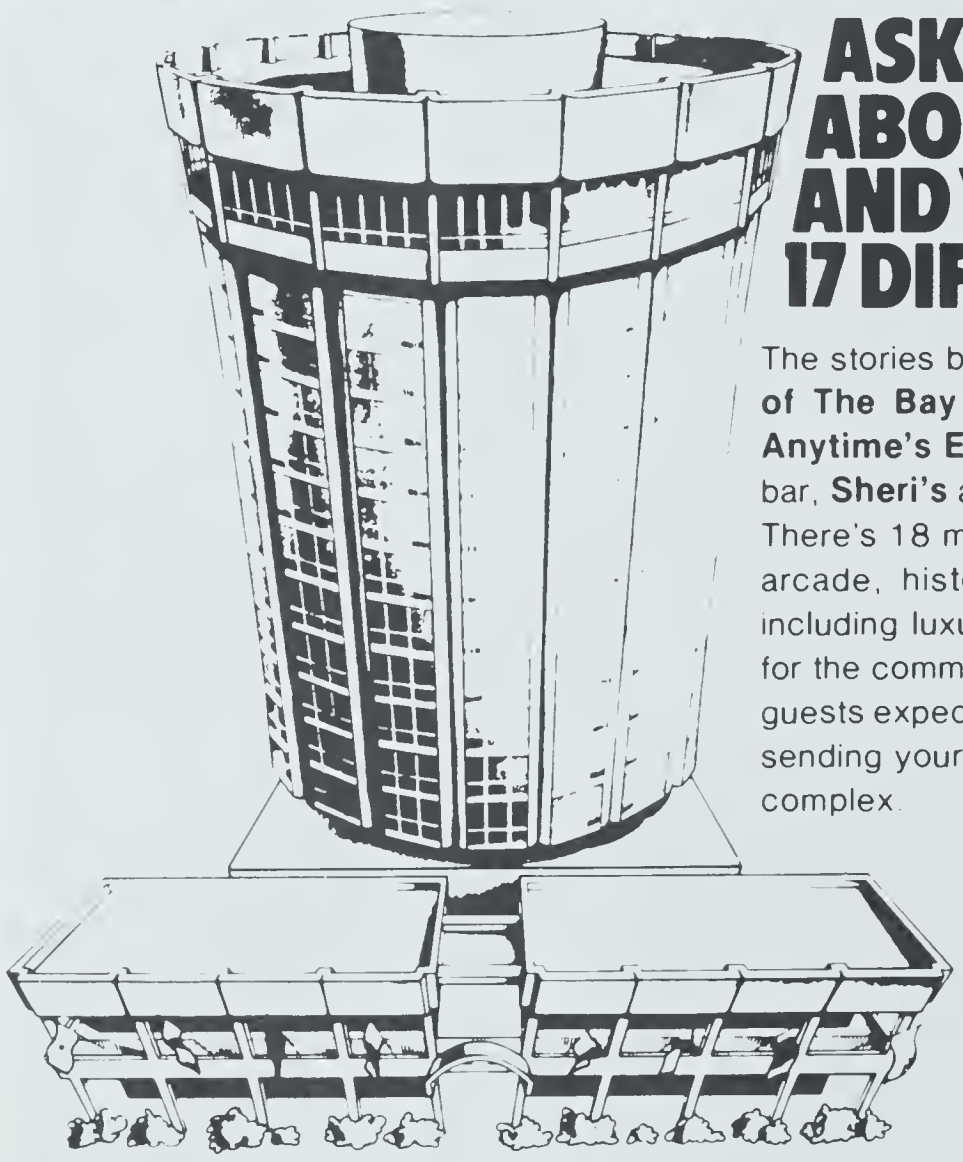
Three cases of atherosclerotic (AAA) were admitted to the urologic service of CMMC. Two presented with prostatism and one with right renal colic. Two were ruptured: one had an acute rupture and expired during surgery. The other had chronic rupture and did well postoperatively. Diagnosis was made in two because of calcification in the excretory urogram and in one by cystoscopy. Culp[10] et al reported calcifications in 65% of their patients and Labardini[13] reported an abnormal IVP in almost 25% of his patients with AAA. Angiogram is a confirmatory tool.

REFERENCES AVAILABLE UPON REQUEST

CLASSIFIED ADVERTISING

Continued from page 15

PEDIATRICIAN—Wanted to join Board Certified, established practicing pediatrician with extensive practice in general pediatrics, pediatric allergy, consulting pediatrics. Outstanding geographic, economic and professional opportunity. Minimal night & Weekend work due to cooperative arrangements. Salary negotiable, early partnership or purchase of practice.



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GET ON THE TRACK FOR FALL 1981

It started in 1898 as the Western of Alabama Freight Depot. This wonderful old depot in the heart of Montgomery's Historical District has a new purpose. By fall of 1981 it will become a most unique hotel. Adjacent to the Civic Auditorium and Alabama River, the Sheraton Riverfront Station will feature two restaurants, two lounges, meeting rooms, and the most unique guest rooms you've ever seen. Put your clients on the right track. Reserve Montgomery's historic hotel. Open October 1981.

Sheraton Riverfront Station

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Valium® IV
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral form* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.
Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.
INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*
Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least ⅓, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs. Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.
Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.
Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam/Roche), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
INJECTABLE: Although promptly controlled, seizures may return; re-administer if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.
Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.
Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam/Roche) therapy and are of no known significance.
INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.
In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.
Dosage: Individualized for maximum beneficial effect.
ORAL—*Adults*: Anxiety disorders, relief of symptoms of anxiety, 2 to 10 mg *b.i.d.* to *q.i.d.*; acute alcohol withdrawal, 10 mg *t.i.d.* or *q.i.d.* in first 24 hours, then 5 mg *t.i.d.* or *q.i.d.* as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg *t.i.d.* or *q.i.d.*; adjunctively in convulsive disorders, 2 to 10 mg *b.i.d.* to *q.i.d. Geriatric or debilitated patients:* 2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg *t.i.d.* or *q.i.d.* initially, increasing as needed and tolerated (not for use under 6 months).
INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)
For dosages in infants and children see below; have resuscitative facilities available.
I.M. use: by deep injection into the muscle.
I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*
Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcoholic withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children, *administer I.V. slowly;* for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available. Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.
In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.
Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.
Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500; Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10. Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse" and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium® (diazepam/Roche) Ⓥ, please see the preceding page.
Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

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JOURNAL

of the Medical Association of the State of Alabama

VOL. 51, NO. 5, NOVEMBER, 1981

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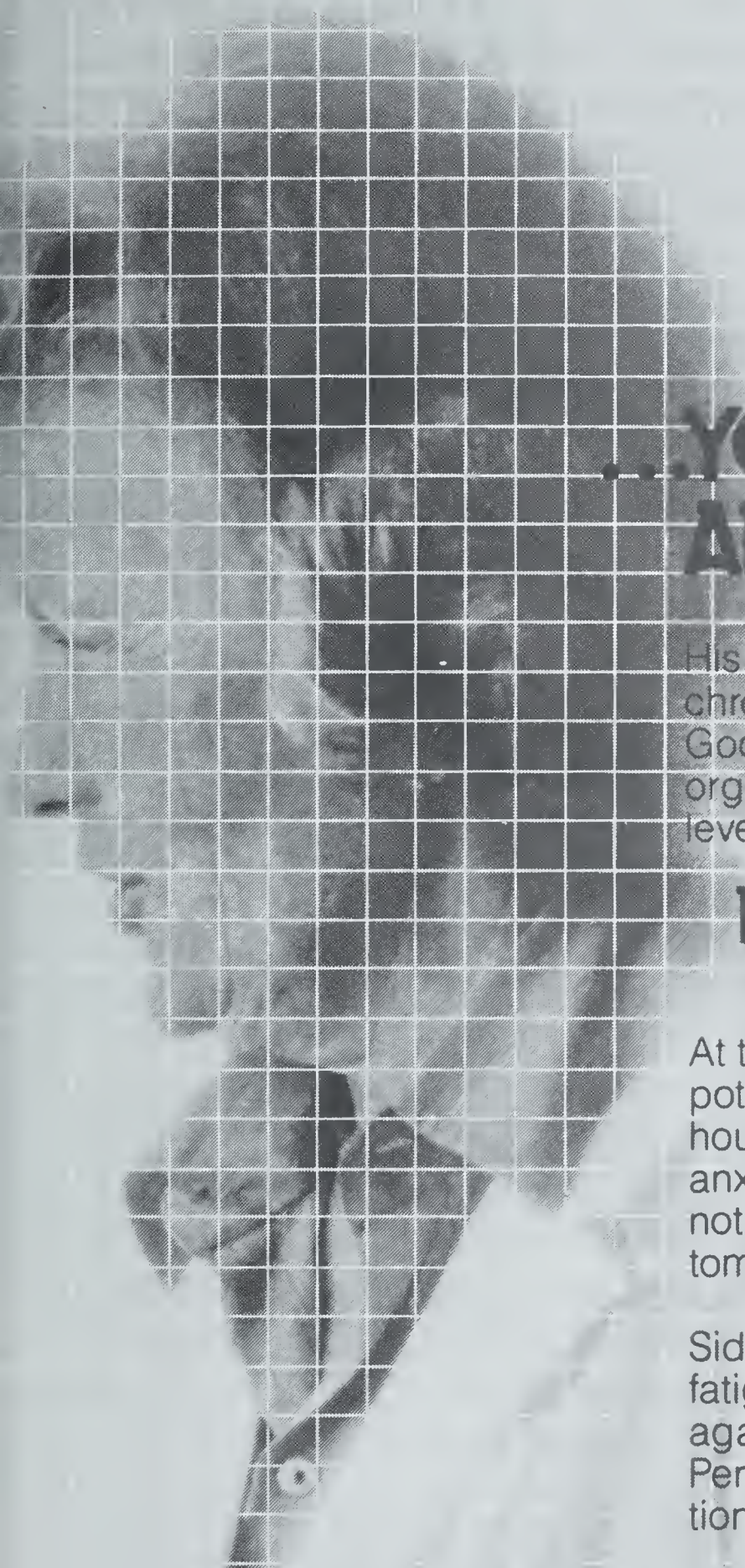
UAB Physician/Scientist Dr. Bennett

Owes It All To Yellow Label Syrup

THE PATIENT THINKS HE HAS HEART TROUBLE...



...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

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diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

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Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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On The Cover

UAB's J. Claude Bennett, M.D. lives in a world of high technology, science and old-fashioned, low tech medicine—all made possible by his father's syrup plant. Story page 8. Master cover photo by Rhonda Lynn.

Reviewing Professionalism

Physicians may be heard to complain from time to time that they no longer have the professional esteem they once did in the public's eyes. This conviction seems to be supported by various polls showing that, while Americans like *their* doctor, they are not nearly so fond of physicians as a group.

Commenting on this in *Harper's* magazine several years ago, Jacques Barzun, regarded by many as the dean of American intellectuals, noted that *all* the learned professions are now under siege.

Part of this general disaffection derives, he wrote, from the general unrest and impatience with authority in the Western world, "coupled with the belief that anything long established is probably corrupt."

Until very recently, the Columbia Professor Emeritus commented, "doctors in this country were revered as in an earlier day only the clergy could hope to be." But the changes in public reverence are certainly not confined to medicine—lawyers, too, are under seige, as are scientists, professors and teachers, ministers, and just about all of the learned professions of old.

Some of it may certainly be due to capricious public attitudes, Prof. Barzun said, but a great deal of the blame can be placed squarely on the doorstep of the professions themselves. Professions, properly so called, should be self-policing and self-correcting mechanisms maintaining the highest standards of ethics and probity in terms of competence and in all other dealings with the laity. " . . . the modern professions have enjoyed their monopoly for so long that they have forgotten that it is a *privilege* given in exchange for a *public benefit* . . . Forgetting the great principle of reciprocity will ruin any profession . . . The regulation of business came about because business did not regulate itself . . ."

Other professions, he wrote, have similar problems, and he is unsparing of his own, teaching. Like doctors, teachers used to be regarded not only as having the best brains but as also the most dedicated and most self-sacrificing. Today, he charges, many if not all the learned professions are far more interested in the economic protectionism of their guild than in elevating the art and science of their profession—once considered the major function of any professional organization. Finally, Prof. Barzun says:

"The message from the professions today is that their one hope of survival with anything like their present freedoms is the recovery of mental and moral force. No profession can live and flourish on just one of the two . . . What the professions need today is critics from inside, men who know what the conditions are, and also the arguments and the excuses, and in a full sweep of the field can offer their fellow practitioners a new vision of the profession as an institution."

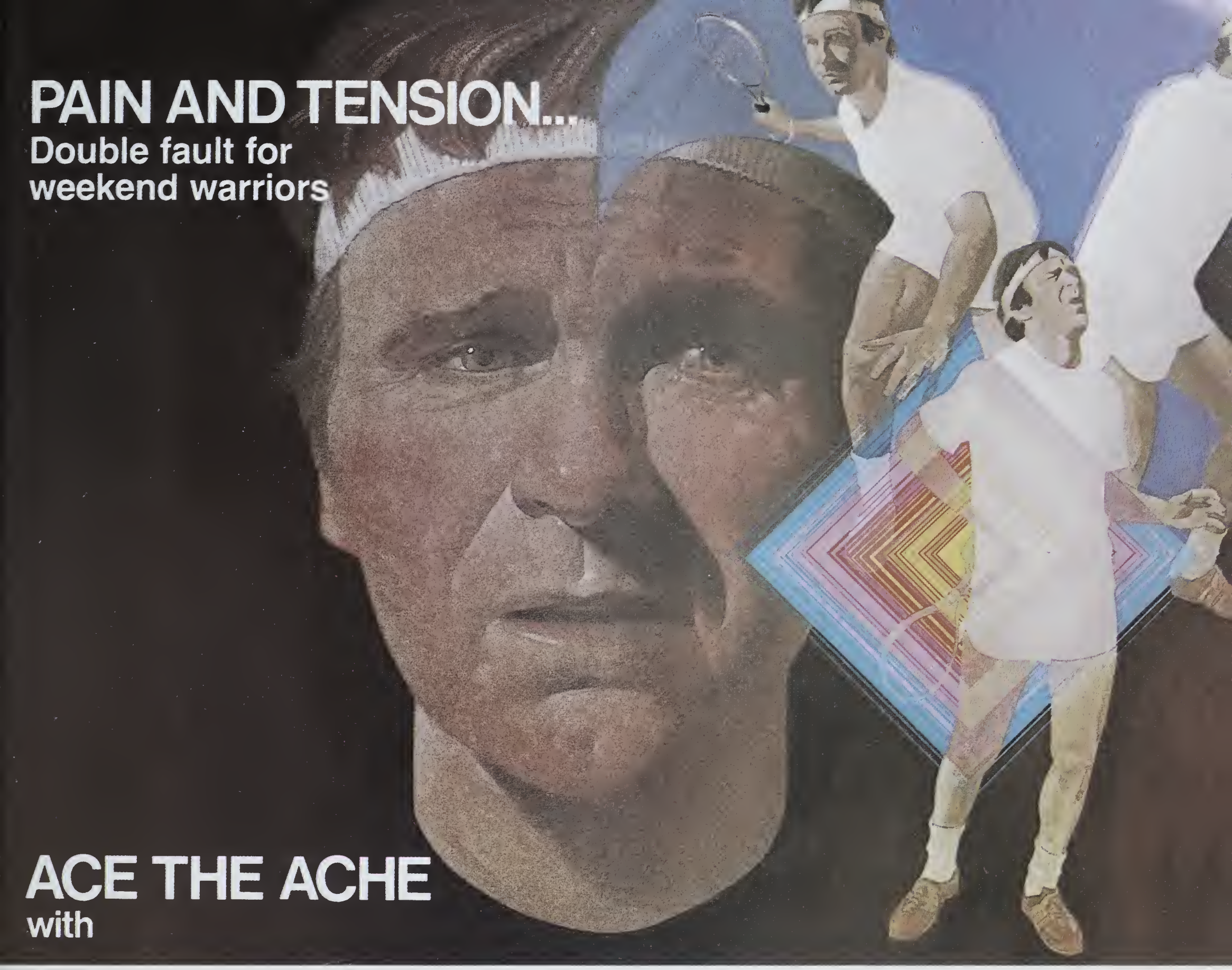
In short, Prof. Barzun argues, to be once again *treated* like professionals, the professions must once again *act* like professionals.

Such a commentary may be unpleasant, and could be dismissed out of hand were Prof. Barzun alone in his views. But they are shared by many.

Alabama physicians have all the necessary mechanisms in place, through peer review and the enforcement of medical ethics. In the final analysis, it is the responsibility of individual doctors to work with their colleagues and their Association to re-establish professionalism in all that the word implies.

The machinery is there, the good intentions are there. Put them to work.

S. Lon Conner
Executive Director



Equagesic®℃Ⓥ

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

*__INDICATIONS:__ Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information, FDA has classified the indications as follows
"Possibly" effective, for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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for mild to moderate pain

Wygesic®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e g driving a car or operating machinery Patients should be cautioned accordingly
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS
The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone, nalorphine and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I V ,simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended.

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J. Kendall Black, Jr., M. D.
President

PRESIDENT'S PAGE

Are We Killing The Goose?

The medical profession has been subject to a number of paradoxical attitudes and opinions by the general public as well as its own membership since the time of its inception.

The present is no exception to the past. Recent surveys indicate that about 85% of the population is satisfied with their personal physician and the quality of care rendered by the medical profession. Eighty percent of the population ranks us only second to scientists in general as an ethical profession. But 78% of the numbers in a recent poll felt that we were grossly overpaid. Similarly, recent polls have indicated that both in the public and in the professions mind, health care costs are a number one problem. The Voluntary Effort is enthusiastically endorsed and supported by physicians, yet medical care costs are increasing at a 15% annual percentage rate and the physicians share of the health care dollar has recently increased from the normal twenty percent to approximately 27%, according to *U.S. News and World Report*. Numerous recent media reports written, spoken and televised, have addressed the issue of health care costs and the burgeoning explosion (so perceived) of physicians fees and incomes.

I present these facts knowing full well that most of you have heard them time and again and they are no surprise. I also know that based on the hours of work, the nights, weekends and holidays missed, and the dedication and quality of care that are rendered, that the vast majority of physicians fees for services rendered are fair, just and more than equitable.

Rather, in presenting you with these numbers, I use them to point out that we as a profession must not let a few bad apples spoil the batch. I realize that I am a specialist practicing in an urban setting and that I was reared in the city and have never been behind a plow in my life but I think that the analogy of the mule plowing a straight furrow is correct. I am told that if the plowman stares intently at the ground before him that the mule will tend to wander in the furrow and it will be quite crooked. However, if the plowman looks up and ahead and plows toward a distant point, the furrow will be straight.

I submit to you that it is imperative that we in the profession look toward the distant goals and forego any shortsighted actions especially with regard to our fees that might well be counter-productive to our independence. Organized medicine has long maintained the position that it is the responsibility of the profession through peer review to govern and police itself. Even Mr. Fuchs, a frequent critic of medicine, has stated that the physician is the one key to exert intelligent restraint on health care costs.

We are essentially the last of the independent professions in this country. I would ask you: Is the instant gratification of perceived financial need worth the loss of the freedom and independence that we now enjoy? Are we willing to kill the goose regardless of the long-term consequences?

J. Kendall Black, Jr., M.D.

UAB Physician/Scientist Dr. Bennett Owes It All To Yellow Label Syrup

by William H. McDonald

We like Yellow Label
Always On our table

During the 30s and 40s, that radio jingle, primitive perhaps by today's standards, echoed the length and breadth of Alabama, from the mountains to the gulf. Alabamians by the thousands heeded the suggestion and bought Yellow Label Syrup.

Because they did, J. Claude Bennett, M.D., was able to pursue a long and intensive education in science and medicine that prepared him for the many hats he wears today—Professor of Medicine at UAB, Director of Clinical Immunology and Rheumatology, Chairman of Microbiology, Director of the Multipurpose Arthritis Center, Senior Scientist, Cancer Research and Training Program. And so on.

Dr. Bennett's father owned the syrup company in Birmingham. He had figured his son would get all that college education out of his system one day and return to manage the plant. But when Dr. Bennett won his M.D. from Harvard Medical in 1958, the elder Bennett concluded, sadly, that his only child just wasn't cut out for the syrup business. He sold the plant.

Mr. Bennett, now 80, still goes to the plant for a few hours every day. Eight blocks or so to the South, his wayward son may at that very moment be concerned with a somewhat different technology—cloning cells in what is said to be the only Mammalian Cell Culture Center in an academic setting anywhere.

Dr. Bennett, 48, has a rare combination of gifts and skills, according to his Medical Center colleagues. A brilliant scientist to whom the arcane language of molecular biology is as familiar as his Southern idiom, he is also an intensely compassionate physician.

Dr. Bennett is at home in the far horizons of molecular biology but is a tender, caring physician to arthritis patients; a superb laboratory man who loves solitary grappling with problems, he is an inspiring leader who almost single-handedly lifted the Medical School out of its bad national showing in the basic sciences and made it a leader.

A modest, self-effacing man whose habit of hiding his light under a bushel is notorious around 7th Avenue, he is also an eloquent lecturer who has been known to fill the faculty rooms to standing-room-only when he is scheduled to speak on, say, recombinant DNA, the genetic engineering that figures to change the face of medicine and industry alike in the last decades of this century.

Although arthritis research has expanded logorithmically in the past few years, Dr. Bennett is, first and last, dedicated to the here-and-now treatment of his patients with traditional methods of physical therapy, aspirin, orthopedic intervention. When miracles are real, he'll use them; not until then.

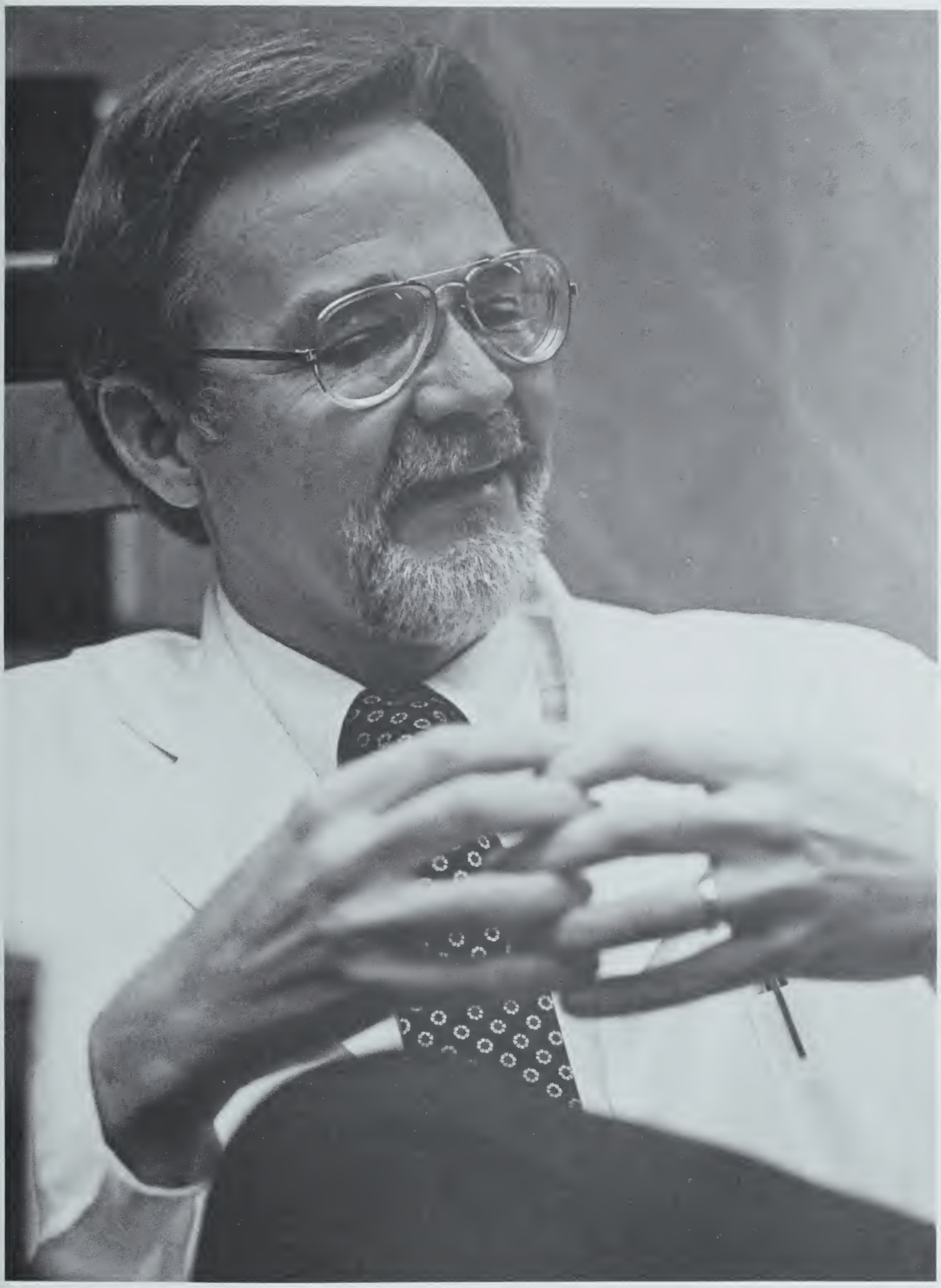
He has his eyes on the stars but his feet firmly planted on the Alabama soil whence he sprung.

His studies carried him to Harvard, Mass. General, the National Institutes of Health (where he worked with a constellation of superstars in molecular biology), Caltech and other points, a relentless pursuit of knowledge, he freely confesses, made possible because his father could afford it—or, more precisely, enough syrup fanciers had taken the Yellow Label jingle to heart.

Contrary to his father's apparent belief that his son could have been saved for the syrup world until he got his M.D., Dr. Bennett can remember no time in his life when he did not want to be a physician.

Where the original inspiration came from is shrouded in mystery. It couldn't have been either of his grandfathers, he says, because one was a minister and the other was an undertaker. It may have been that he was influenced in some degree by his Birmingham pediatrician, the late Jerome C. Chapman, M.D., a kindly man. But Dr. Bennett believes it began even before Dr. Chapman entered his life.

The 1981-82 President of the American Rheumatism Association, Dr. Bennett is fairly sure where *that* interest



began. His parents had a family friend, a widow, who developed systemic lupus, a rheumatic disease.

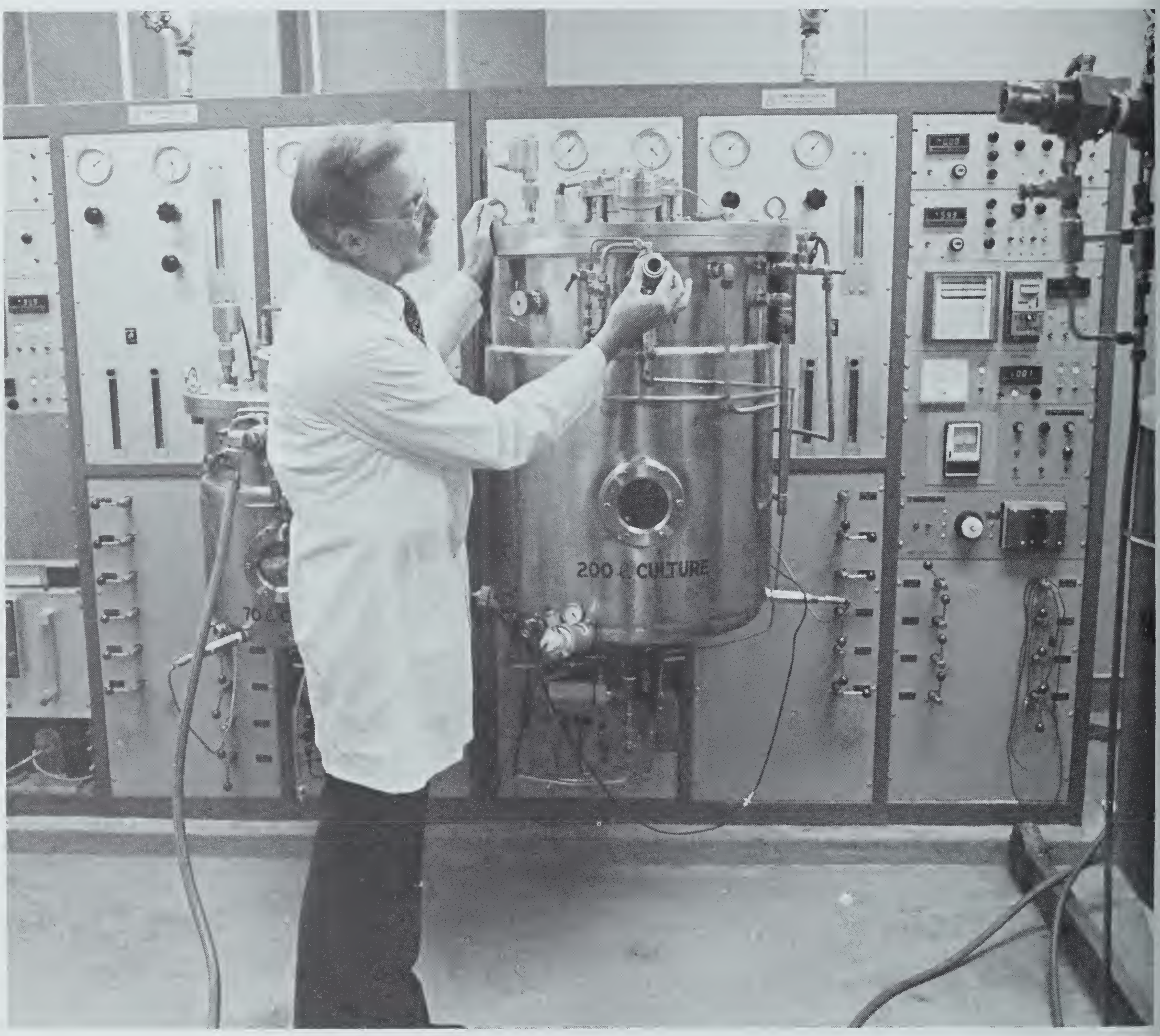
"The disease was very destructive to her," Dr. Bennett recalls of the lady who had once been his baby sitter. "It was a time when steroids were just beginning to be used. She developed all the complications that go with steroid treatment and finally died. Her disease interested me, her death made a deep impression on me."

Here all these years later, while there have been many recent successes in the clinical management of lupus, it is still baffling in terms of cause, Dr. Bennett says.

His training in the rheumatic diseases began in his senior year at Harvard Medical, where he chose an elective with Walter Bower, M.D., then Chief of Medicine at Massachusetts General, a powerful figure in American rheumatology. That interest abided in all his subsequent training in molecular biology. And it came at a time of exponential growth in scientific knowledge about the rheumatic diseases. Dr. Bennett says:

"If you look at the number of papers presented at national medical meetings, the number of papers at specialty meetings, the percentage of increase in those on rheumatology exceeds the percentage increase in everything else.

"Part of that explosive growth is due to the fact that research in rheumatic diseases is in a way very different from what you do at the bedside. That's probably because we don't know a whole lot to do at the bedside. People in the labs are doing a lot of exciting, fundamen-



UAB's J. Claude Bennett, M.D., whose father wanted him to come back to Birmingham to run the family syrup plant did return, but to technology of a different sort. A few blocks to the south of his father's old Yellow Label Syrup plant, Dr. Bennett is shown here with the only large-scale suspension cell factory in a university setting in the country. The Mammalian Cell Culture Center clones cells for various studies and is also scheduled to produce, this winter, 90 patient doses per day of Interferon.

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Alcohol	5%

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DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.
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tal research. But when they go to the bedside, into the clinic, they are still having to do everything the old way—diagnosis, physical therapy, aspirin.

"It's not like cardiology, where research into the pathophysiology of the disease and clinical management stay much closer in parallel.

"In rheumatology, the research mode and the clinical mode have not developed in parallel, but the research mode has attracted a lot of very good people into the field, mainly through immunology, and that is now beginning to produce results. It has really turned around in recent years."

Question: Then you would expect important developments in the near future?

"Yes, but there have already been important developments in rheumatic diseases in the last 10 years. In four areas, particularly, we have had significant breakthroughs:

"1. Understanding the metabolic pathway that leads to gout and development of drugs that specifically block the synthesis of uric acid.

"2. In the area of rheumatic fever, there is a new understanding of the relationship of streptococcus and its antigens to producing cross-reacting phenomena in the heart, causing heart disease. Therefore, we have sound understanding for the basis for using penicillin therapy as a prophylaxis.

"3. The whole area of developing non-steroidal anti-inflammatory agents . . . . We are now seeing the whole biochemical mechanism by which these inflammatory mediators get produced, how synthesis is altered. And we are getting at the fundamental initiators of what happens in the basic inflammatory process.

"4. Orthopedic surgery and development of materials that allow effective joint replacement—the synthetics, the cement that holds them in place. The people working in basic biomaterials have made enormous contributions. Of course, the skills of the surgeon in applying them has been all-important. Hip replacement, knee replacement—they really work, you can only stand in amazement at some of the things that are being done."

James A. Pittman, Jr., M.D., Executive Dean, recalls that when Dr. Bennett, who had returned to the faculty in 1965, took over the Department of Microbiology in 1970, "microbiology was a wasteland, at rock bottom—our students were making their worst grades on national boards in microbiology."

A few years after Dr. Bennett took charge, Dean Pittman recalls, "They were making their best grades in microbiology."

Confronted with this encomium (which is the way you have to jimmy information out of J. Claude Bennett, M.D., since he simply refuses to toot his own horn), Dr. Bennett smiles boyishly in his comfortable rocking chair, surrounded by the books of molecular biology and rheumatic disease, then demurs mildly:

"Jim is not being entirely accurate in that, because it wasn't just microbiology. All the basic sciences had been underemphasized—although I wouldn't call them wastelands—because the medical school was built around the Department of Medicine, and was built around people like Tinsley Harrison; and the Department of Surgery around people like Champ Lyons and John Kirklin.

"The University resources had gone into that area and a lot of the revolutionary development of our school in the 50s and 60s, from the standpoint of really excellent science, was impeded by the public relations image of this institution. I had difficulty recruiting from distant places in pure science."

Question: Are you saying that you had pretty much of a star system, and that this handicapped the basic sciences?

"Yes, we did. Yes, we did. There were a lot of complex reasons, but basically the institution's resources had not gone into basic science. They made a commitment, when I became chairman of Microbiology, that they would put enough resources in there to begin to change some of the basic science departments. That happened to be the first one they hit. If you have new resources you do new things. And that happened."

Dr. Bennett has himself been given more credit for this turnabout than he will freely acknowledge, short of the third degree. Thus,

Question: But Dr. Bennett, isn't it true that your being such an unusually qualified person to bring this about, as the catalyst, had a lot to do with it—specifically because of your credentials as a physician and a scientist?

Dr. Bennett smiles shyly when the light he keeps trying to hide under a bushel is exposed:

"Well, yes, I think being an M.D. interested in science allowed me, in Microbiology, to take advantage of the strong research relative to this field that was already in the other clinical departments—Medicine, Pediatrics, Pathology, and so on.

"I saw that these people could be brought into work in micriobiology. Some of the best people, then and now, relating to microbiology, are really secondary people, with their primary appointments in the clinical departments: infectious disease, all of clinical immunology, all of virology and pediatrics, the chronic pediatric diseases.

"Those people have been very loyal, very supportive and do a lot of teaching for us that is really the responsibility of the other departments."

Question: If I may interrupt you, Dr. Bennett, this didn't just happen, now did it? Didn't it happen because you provided an unusual kind of leadership? One of your colleagues has written this about you: 'Dr. Bennett possesses in a degree rarely seen the power of attracting able men. He radiates friendship. His good humor, his cheeriness, his aptness

of phrase in illustration, his loyalty, his integrity and his stability make him . . . probably THE man at this institution whom everybody looks up to.' How do you answer that?

Dr. Bennett blushes visibly beneath his neatly trimmed goatee but fields the question nicely in his characteristically modest way:

"We were making use of what we already had, getting the act together. We gave those people a collegiate spirit. They went to faculty meetings and had equal voice and equal vote with the primary Microbiology faculty. They could have their own graduates within Microbiology, which they didn't have access to before.

"We didn't pay them any money or give them any space, but we gave them these other things that meant a lot to them. That allegiance has been an enormous help to the department as we have now grown in fundamental, basic science.

"It was then that we recruited Roy Curtiss (Ph.D.) to come down and develop molecular genetics, which he has done so beautifully. He came down from Oak Ridge. We recruited Dick Compton (Ph.D.) from Rockefeller and David Bishop (Ph.D.) from Rutgers to come and create molecular virology . . . .

"These were the senior stars. Many of the assistant professors now have tenure and heavily funded research and really good national reputations."

Question: But you also suffered in your recruiting from the civil rights turbulence in Birmingham during this period?

"Oh, yes. It was hard even to get people to come down and look, let alone think about taking a job. Dr. Kirklin's coming in '66 helped in a major way, certainly in the view the outside world had toward this institution. But, like most things, it is never due to any one person but a constellation of things that made it happen."

Question: Could you give me a definition of the difference between microbiology and molecular biology?

"Classically, microbiology is the study of microbes—bacteria, viruses, fungi, Rickettsia and their effects on man—infectious diseases, host immune responses. That's microbiology. It used to be called bacteriology, but in those days little was known about viruses.

"Molecular biology involves studies at the molecular levels in cells or parts of cells, the DNA, the proteins, the RNA, the synthesis. It just so happens that the easiest vehicle to study these phenomenon are microbes. The reason for that is **E. coli.**

"If you want to study a genetic event at the molecular level, **E. coli** doubles itself every 20 minutes, so that you have tens of millions in a period of eight hours. This means you can see a genetic event that occurs once in a million.

"You can even take it further and study bacterial viruses, a virus that affects the bacteria, a bacteriaphage, and it will replicate itself one-hundred-fold every 20 minutes. In other words, you go up logorithmically.

"You can study, literally, the molecular event much better in these cells than in human cells, that at the best will divide only once overnight, and those are mainly tumor cells. Non-tumor cells frequently don't divide at all.

"So that to study events that occur rarely we have to do it in microbes and then extrapolate what we expect to see in man."

Question: You have thus created a laboratory time warp?

"Yes, molecular biology uses the microbes to get there. Therefore you will see molecular biologists, people interested in DNA, RNA and proteins, working in microbiology departments, in biochemistry departments, and nowadays you also see them in pharmacology departments because a lot of drugs—particularly cancer drugs—act at that level.

"In some schools, but not this school, there are departments of molecular biology. We have not gone that route. However, Roy Curtiss directs a graduate program that the federal government calls the Molecular Genetics Training Program, and it spreads across several departments . . .

"There are other things in microbiology that people frequently don't think about. From a commercial point of view, perhaps, it has the largest impact. You think of microbes causing disease, and that's true. Doctors are concerned about that. And we think of microbes as being the vehicle for studying molecular biology, and all the new things happening in genetic engineering, and that's true.

"But there is another area. Microbiology processes are used in terms of almost everything you can name in food processing. There are difficulties in upscaling laboratory processes into commercial processes. The school has just started another program in bioengineering, headed by Dr. Louis Sheppard. Part of what they are interested in is developing an academic program to train people in these kinds of industrial technologies as well as lab technology in how to grow cells."

Question: You are also director of the Multi-Purpose Arthritis Center. How does that fit in with the Rheumatology Division you head?

The Arthritis Center and its interface with the Rheumatology Division, that is your question? Rheumatology is a division under the Department of Medicine. I was made head of it in 1970. We worked very hard toward orienting specifically toward patient care for rheumatic diseases. That's our real job.

"Then we have a research base within the division, with some good people working there, and a very good training program, with seven Fellows in training as rheumatologists, usually that many every year.

"But we were awarded a grant from the federal government to establish an arthritis center, 'a Multi-Purpose Arthritis Center'. The 'multi-purpose' part of it means it is elevated to the same kind of responses and challenges in arthritis that the Cancer Center has in cancer.

"When we accepted the federal grant, we had to become involved in education, on campus, of people who are not just doctors, but physical therapists, as related to rheumatic diseases; nurses as related to rheumatic diseases; social workers; social psychologists; pharmacists as they relate, very importantly, to chronic disease . . . .

"Also, there is Project HELP, for Health Extension Learning Program, a cooperative venture between this institution and Auburn, with its extension program, and the State Department of Health. We have education programs through the county agent system, in cancer, hypertension, dental hygiene, diabetes, arthritis. They are Home Health Demonstrators, Auburn trained, and make contacts in rural areas where there is a low density of doctors.

"Patients really latch on to this. Chronic disease is crippling. You need to learn little tricks, like how to put on your shoes when you can't bend over, how to use the toilet, the shower, tub, how to open doors when you can't grab the handle, or anything else requiring stress or pressure on the hands.

"Learning these little tricks is terribly important. People who don't think about chronic disease, and chronic disability, don't realize how important this is. Health educators, we've learned, can do a better job of this than doctors, who don't take the time.

"We work very hard at getting all these people together. Essentially, between 25% and 35% of our total population will, at some point, have a muscular/skeletal rheumatic disease syndrome that requires going to a doctor. That's an enormous number of people."

Dr. Bennett's whole life has been influenced by people—people he needed to teach him along the way and people who, then and now, need the knowledge he has accumulated, and the gathering and dispensing of it that he oversees with his many titles.

From the kindly pediatrician of his childhood, and the dear family friend with lupus, on through his many associations in research with some of the greats of molecular biology, medicine and rheumatology, it has always been **people** influencing him far more than abstract ideas, he confesses.

Back in undergraduate days at old Howard College in Birmingham, when he was beginning to think of a career in chemistry, it was the Howard Chairman of Chemistry, John Xan, who influenced him to go to medical school and still do research.

Prof. Xan had cancer of the thyroid glands and was a patient of Champ Lynns, M.D. Prof. Xan sent the young Bennett to see Dr. Lyons, who reinforced the thought and subsequently interviewed him for medical school.

Things had a way of coming together all through his studies because of the peculiar coincidence of people at the right time.

Dean Pittman says of Dr. Bennett that, although he is a superb scientist, he would unhesitatingly choose the role of physician if he had to separate his life. Asked to comment on that, Dr. Bennett smiled and said:

"He's probably right. But I would like to believe that I have reached a point where I would never have to face that choice."

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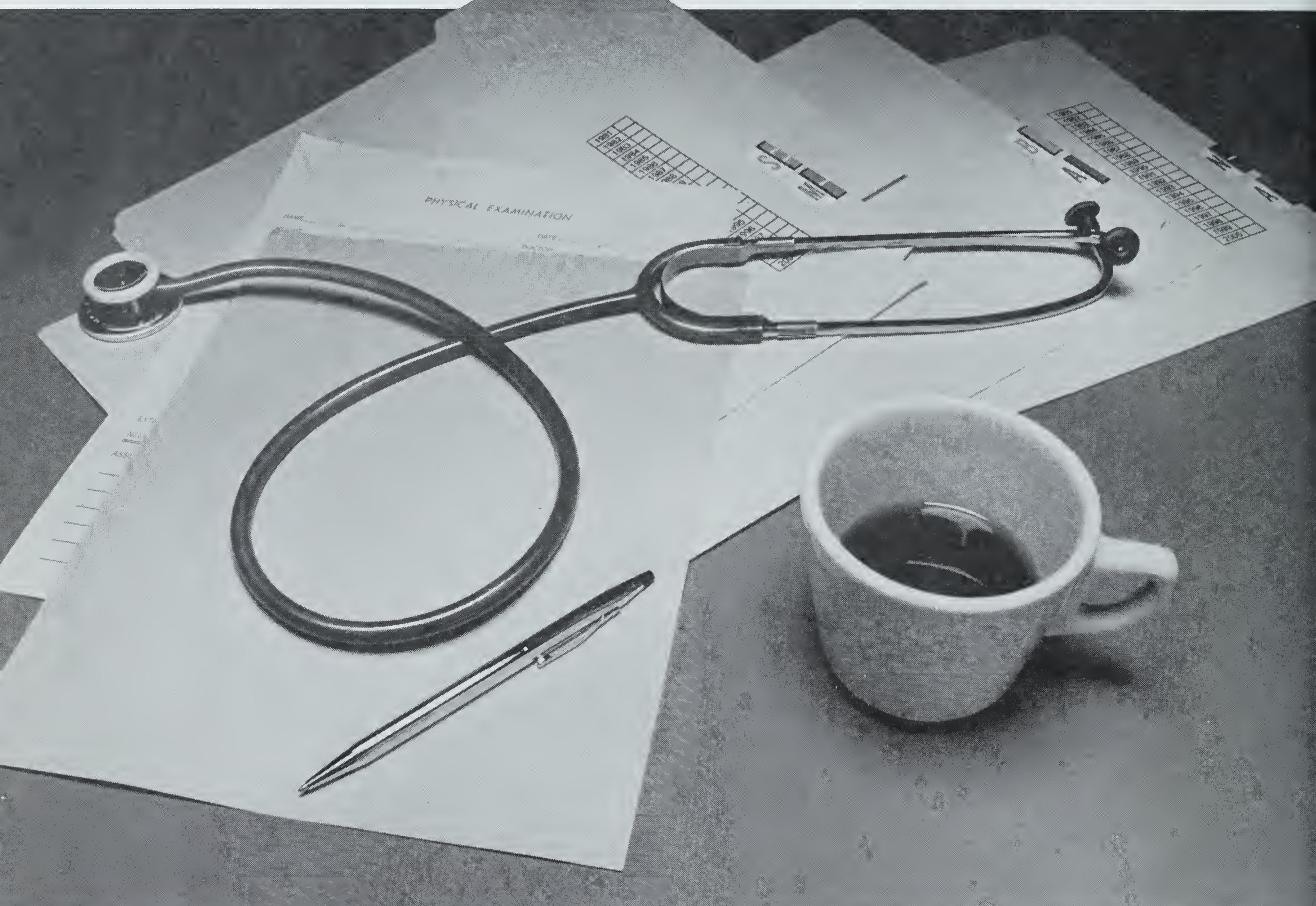

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"Name Your Own Disease"

by
William L. Smith, M.D.
Editor, The Journal

Hoof and mouth disease, tennis elbow—to mention two—are well known disease entities associated with occupations or leisure activities. With changing civilizations all over the world, more and more occupational diseases are being discovered and reported. Have you one to report from your practice?

So far as we know the first occupational disease classifier to publish was Ramazzini. His book, *De Morbis Artificum Diatriba,* was published in 1700. E. R. Plunkett, M.D., in his excellent book, *Occupational Diseases–A Syllabus of Signs and Symptoms*[1] quotes from the translation of Ramazinni's book extensively adding great amusement to his modern work.

Surely some erudite reader of the *Journal* has made a discovery of a new, perhaps rare, affliction caused by work or play. For example, do you know the etiology of "jogger's Nipples," "Hooker's Elbow," and "Plain's Dyspepsia"?

There once was horseman's prostatitis in profusion. Now the stallions have been replaced by the Mustang and the Jeep thereby changing the etiology of this form of prostatitis. Along the same line, a rare case of proof reader's prostatitis has been reported and aired in the New York Times. Your Ed. hopes to avoid this hazard.

Yes, "Hooker's elbow" has been reported. It was first discovered in Alaska among, of all people, ice fishermen. These hardy souls cut a hole in the ice, let down a jig with hooks on a string tied to a wooden stick which they jerk up and down. The result is pain and swelling of the elbow.

"Plain's Dyspepsia" is observed in otherwise adjusted individuals after the Auburn Tigers lose a close one. "Jogger's Nipples" results from jogging *sans* bra. It seems that abrasion occurs from the constant rub of the nipples against the clothing. But think of the great lift by the endomorphs.

No discussion of occupational diseases should ignore the madness of hatters. Actually, it was a palsied shaking that befell the manufacturer of hats in olden days due to chronic mercurealism. This lead to the expression "mad as a hatter."

Let us know of your discoveries, who knows, you might become more famous.

[1]Plunkett, E. R., M.D.—"Occupational Diseases A Syllabus of Signs and Symptoms," Barrett Book Company, 1977.

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REAGONOMICS—WILL IT WORK?

By Eugene Stanaland, Ph.D.*

Inflation Fight

Perhaps the best way to approach an explanation of Reagonomics is through the perceived maladies it was developed to cure. Inflation has been diagnosed as our number one economic ill for some time, hitting the top of the list in January of 1979 at 18%. A simple but very descriptive and useful definition of inflation is: too much money chasing too few goods. Reagonomics programs are directed to one or the other parts of that definition—either to reduce the amount of money in the system or to increase the amount of goods and services available to buy.

The Too Much Money Attack

Fiscal Policy Approach

The "too much money" symptom is addressed through the administration of fiscal and monetary policies. Fiscal policy is merely the goverment's budget—the product of taxing and spending legislation passed by Congress. When Congress spends more money through appropriations legislation than it provides revenues through tax legislation, a deficit results. Government deficits add to inflation in that they are financed by borrowing from the Federal Reserve Banks. Consequently, government bonds are traded for demand deposits which, when spent by the government, become a net addition to the money supply.

This process is called monetizing the debt. Deficits financed by borrowing from the private sector are not as inflationary because demand deposits are drawn down to pay for the bonds, offsetting the demand deposits the government acquires by virture of the sale of the bonds. However, this process of bidding in the private money markets instead of borrowing from the Federal Reserve does result in interest rates being bid up because the government is bidding against other borrowers in the market.

The Reagonomics prescription for this deficit aspect of the illness is a reduction in federal spending to the tune of approximately $43 billion. The object is to bring spending in line with revenues so deficits will not have to be financed with money supplied by increased borrowing from the Federal Reserve or with interest rate increases resulting from competing in the private money markets to finance the deficit.

Monetary Policy Approach

The other attack on the "too much money" symptom is tight money policy. Monetary policy is administered by the Board of Governors of the Federal Reserve System. They attempt to control the quantity of and/or the cost of money in the economy. Inflation suggests that there is too much purchasing power in the economy relative to the amount of goods and services available to buy.

This diagnosis leads to the conclusion that there should be a reduction in the rate at which money is being added to the economy. The Board of Governors utilizes its tools—discount rate, reserve requirement, open market operations, moral suasion—to reduce the amount of credit being extended through the banking system. (The next article will explain how the Federal Reserve Banking system works.)

Too Few Goods Solutions

The "too few goods" half of the problem has been addressed by Reagonomics through deregulation legislation and tax law changes. These efforts are designed to: (1) encourage saving, (2) promote investment, and (3) increase work incentives. All of these procedures are directed toward increasing production so there will be more things to buy—the basis of supply side economics.

Deregulation

Increasing concern in recent years about such things as quality of our environment, safety of the work place, equal employment opportunity, access for handicapped, consumer protection, etc., has led to a great deal of legislation which directly and indirectly affects the production process. The benefits sought through these efforts do not come free. Increased costs of production and delays in production, along with the legal costs of implementing, defending, and prosecuting, have added to inflation by reducing the rate at which we turn out

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goods and be directly adding to the cost of production. Legislation designed to reduce the amount of regulation or extending the time periods to comply with them have been viewed as aids to increase output and reduce costs.

Tax Changes

Tax law changes have been directed toward two objectives: (1) increase saving and investment and (2) increase incentives to work. The first set includes the new accelerated depreciation rules; the All Savers Certificates which encourage saving by offering tax free interest income up to $2,000 for a couple; reduction of the maximum tax rate from 70% to 50%; and increasing the amount of money that can be placed in tax sheltered retirement plans.

All of these emanate from the knowledge that it is capital that increases productivity. Tools, machinery, equipment of high technological nature—all of these expand man's control and power over the environment. For the past few years our Japanese and West German competitors have been plowing a greater percentage of their GNP back into investment in capital than we have. While we have done a creditable job of developing our human capital, we have neglected our hardware.

An economy can direct resources to the development of capital goods such as machinery, factory building, technology, etc., only to the extent that it frees resources from the production of consumer goods. The process of saving provides those resources. Income saved results in a reduction in the demand for consumer goods which releases resources for the production of capital goods.

We have not been saving sufficient amounts in our economy to sustain an appropriate level of capital investment. The environment of inflation and taxes in our country has discouraged saving. Spending—rather than saving—puts pressure on prices of consumer goods and creates a shortage of funds available for investing. The tax law changes described above are an effort to create a more attractive environment for both saving and investing.

Incentive Tax Changes

The across the board tax cut of 25% over a three-year period was a response to the belief of supply side economists that as a result of the high tax rates, coupled with bracket creep caused by inflation, the government was collecting less revenue than it would have if the rates were lowered.

In other words, we have reached the point where increasing tax rates would actually result in less revenue being collected rather than more.

Example: I am called by a client in Portland, Oregon, to come out and do a seminar for their management people. If I am in a 70% tax bracket, my fee of $1000 would be split $700 to the government and $300 to me. The incentive for me to go would obviously be affected by the fact that the government will get more than I will for the trip. The supply side people say that if the Government were willing to split 50/50 I might be encouraged to make the trip and generate the revenue. In this case the Government would get 50% of $1,000, while under the 70% rate it would get nothing.

I am not aware of any research that produces conclusive evidence about the validity of this incentive theory for all levels of income, or at what income or tax levels it would become operative. For the most part, the profession is still in a quandary about the ultimate incentive effects of tax rate changes.

What Has Happened

The Prescription

In summary, Reagonomics is a compilation of supply side economics which address the "too few goods" part of the inflation definition, and monetarist policy and fiscal conservatism which deal with the "too much money" part of the problem. The monetarist policies have been invoked and are still in place. The Federal Reserve has been holding the line on the money supply and letting the interest rates go wherever the forces of the market take them—mostly up. A significant cut in government spending has survived Congress along with the passage of the tax incentive legislation.

What Was Supposed To Happen

The hoped for results of these policies were: holding the line on money supply growth and reducing deficits would bring a return of confidence to the money markets by indicating we were finally serious about controlling inflation. As a result, long term interest rates would fall because a smaller inflation premium would be charged. Long term markets opening up would reduce the pressure on rates in the short end of the market as corporations would once again be able to afford long term debt financing. In both cases lower rates would encourage investing.

The tax incentive program would stimulate a great deal more activity both in production and consumption which would increase the tax base to the point where the tax reduction revenue losses would be offset.

What Is Happening?

Things are not going well. Most of the difficulty seems to be a lack of confidence in the money markets brought on by the fear that the Fed will not hold the line under pressure from declining auto, housing, and agriculture industries; the belief that the tax cut was not sufficiently offset by reductions in government spending; and some doubt about the amount of incentive that would be created by the reduction in the income tax rates.

And, if all that were not enough, the economy is slipping into recession which causes an automatic increase in government spending through unemployment com-

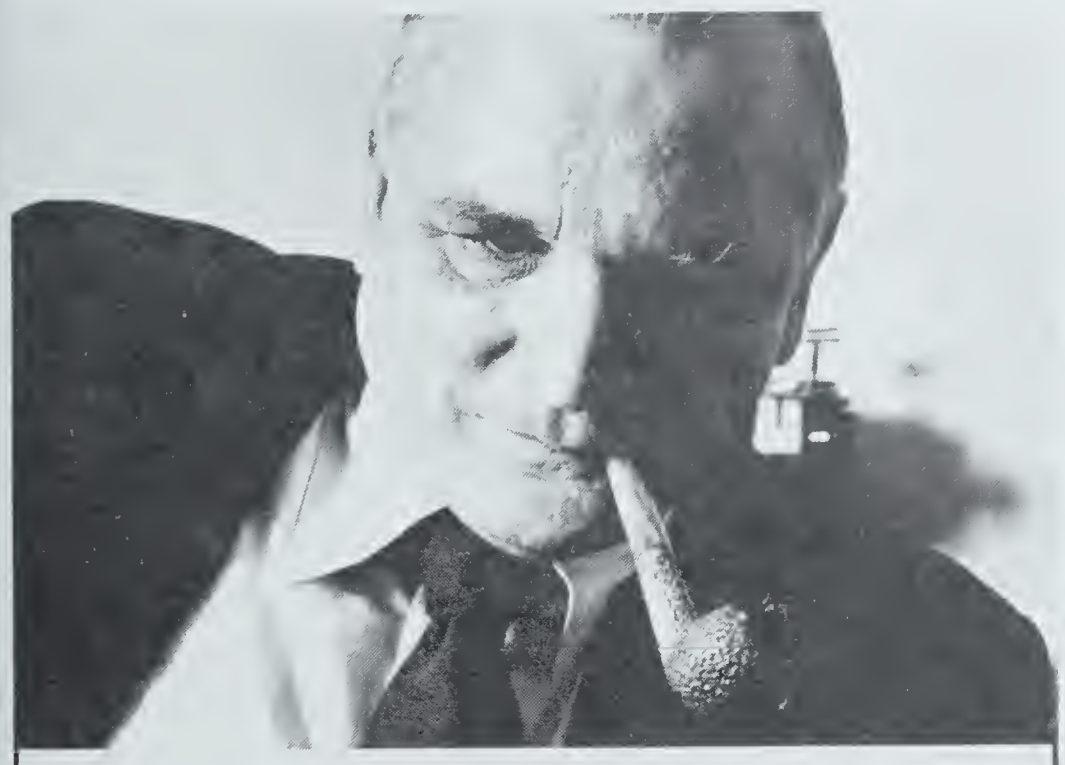
pensation, welfare programs, etc. Hence, the deficit, instead of declining, has risen.

Prognosis

Can we conclude failure? It would seem a bit premature since most of the "too few goods" prescriptions are only a couple of months old. The basic structure developed by Reagonomics seems to be one, for the most part, that would generate confidence and optimism in the business community. This should result in more investment, jobs, spending, and economic prosperity.

If we can get beyond the present difficulties with Congress and the Federal Reserve Board not buckling under to the political pressures, we should be off to a long sustained period of real economic growth in our country. I think that a further reduction in Government spending and a reduction in the size of our tax cut would contribute a great deal toward the happy outcome. Considerations of the size of these two proposed cuts should be done in the context of the fact that we presently want the Government to buy and deliver to us approximately $60 billion dollars of goods and services for which we are not prepared to pay.

Government spending should be brought in line with our willingness to pay the bills for what we are now getting before we talk about reducing taxes.



Dr. Robert Smithdas is blind, nonhearing, and nonverbal. He is a published poet.

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GREAT HERITAGE: A Son's Tribute

By Robert K. Wilson, Jr., M.D.*
Troy, Alabama

He was 5′3″ tall most of his adult life although, I'm certain that in the last few years he was only 5′2″ ("with eyes of blue," as the old song says). He probably weighed 100-110 pounds ("soaking wet in my combat boots" is how he'd have said it). He was one of a vanishing breed, affectionately referred to as "the old-fashioned country doctor."

Two sayings would characterize him: "A merry heart doeth good like a medicine" is one from the Holy Word (Proverbs) and "The art of medicine gets the patient in a good mood while nature does the healing" (Voltaire).

I don't want to imply that all this man had was a sense of humor—though he was tremendously blessed with that. He was a man who used all his God-given senses and with Osler of old could make an astute diagnosis before the ink on the laboratory or x-ray requisitions was dry.

In 1978 he was asked to "say a few words" at the West Alabama Health Council Meeting regarding his 50 years of medical practice—that's right—50 years!

He cited multiple examples of changes in medicine that he saw with his own eyes from his medical school days to the present. Banting and Best had "discovered" insulin in 1927. Before that, severe adult onset diabetes and juvenile onset diabetes were fatal. He saw the whole spectrum of Rh disease. Initially, people described erythroblastosis fetalis and kernicterus—death or morbidity. Then blood types were discovered and the Rhesus factor and finally, exchange transfusion, and more recently, Rhogam that essentially can prevent the disease.

He saw electrocardiography go from three leads to what we have today (twelve leads at once, echo, phono, etc.).

He essentially witnessed the antibiotic era—from nothing, to sulfadiazine, to penicillins, to aureomycine, etc., etc. He witnessed the development of sophisticated equipment in the clinical laboratory, in the radiology department, in the operating room and in the private office. He saw the virtual irradication of polio and other dread diseases and also witnessed the development of the field of nutrition ("cures" for scurvy, rickets, beri-beri right on up to the hyperalimentation protocols of today).

Of course, he also saw the spiraling cost of medical care, the trend towards specialization, and the necessity and growth of organized medicine.

He concluded his talk with these words: "I still get excited about the practice of medicine after 50 years."

He then quoted Maimonides and said: "May there never develop in me the notion that my education is complete but give me the strength and leisure and zeal continually to enlarge my knowledge."

Finally he said, "This has been, and I hope it will remain, my creed."

Consider that for a moment. We have a seventy-six year old 5′3″ ball of energy extoling the virtues of CME! It's wonderfully incredible!

I had been invited to hear him speak but I had something "important" that I had to do. I'm grateful I have no way of looking back to see what was so "important" then that kept me from hearing first hand what he had to say.

This man's love for medicine; his respect for life; his love for his family; his sense of humor and the joy of living; his ability to think deeply; his gift of saying just the right thing at the right time—all these made him a man who was exceptionally unique.

What a tremendous heritage I have! I miss you, Dad.

*Dr. Wilson, Sr. practiced in Aliceville, Alabama (Pickens County), for over 30 years. He was a member of AMA, MASA, and a life member of SMA until his death December 4, 1980.
Dr. Wilson, Jr. is formerly from Pensacola, Florida, where he practiced for 13 years. In March, 1981, he was appointed Medical Director of the Charles Henderson Child Health Center in Troy, Alabama.

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MENINGOCOCCAL INFECTION IN ADULTS

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MENINGOCOCCAL INFECTION IN ADULTS

Meningococcal infection remains a major world-wide health problem but rarely is mentioned in review articles of pneumonia and bacteremia. Two cases of meningococcal infection in adults are presented and demonstrate the varied clinical manifestations of this disease which range from a self limited bacteremia with pneumonia to a fulminant septicemia with meningitis terminating in death. Early institution of antibiotic therapy with penicillin or chloramphenicol is effective and antibiotic prophylaxis with rifampin is indicated for close contacts.

Key words:
Meningococcemia
Pneumonia

Meningococcal infection remains a major world-wide health problem with an estimated 600,000 cases in the period 1939-1962 of which 100,000 were fatal.[1] In addition, no infectious agent can kill a human being with greater rapidity than the meningococcus with death occuring less than two hours after the first symptom.[2] Despite the importance of the meningococcus as an infectious agent causing significant morbidity and mortality, review articles of pneumonia[3] and bacteremia[4] rarely mention Neisseria meningitidis as an etiologic agent. Recent experience with two cases of meningococcal infection in adults demonstrate the varied clinical manifestations of this disease and serve to remind physicians to consider this organism as a possible etiologic agent in cases of pneumonia and septicemia.

CASE REPORTS

Case #1

A 70 year old female was admitted with a six day history of chills without fever, left pleuritic chest pain and productive cough. The patient had a history of chronic obstructive pulmonary disease. Physical exam revealed a dyspenic chronically ill appearing elderly female with a temperature of 100°C, pulse 80 beats per minute, respiration 24 per minute and blood pressure 140/80. The chest was hyperinflated and the lungs had bibasilar rales. Laboratory data showed a hemoglobin of 11.4 g/dl, hematocrit 33.9% and white blood cell count 8,200 with 75 segs, 4 bands, 16 lymphs, 3 monos and 2 eosinophils. A left upper lobe infiltrate was seen on chest x-ray and sputum culture grew normal flora. The patient was started on cephalothin sodium four grams per day and made a slight clinical improvement. When blood cultures which were drawn on admission were reported positive for Neisseria meningitidis (eventually confirmed as group C) the patient was changed to chloramphenicol sodium succinate two grams per day. Although she improved clinically, the infiltrate persisted on chest x-ray and the patient was bronchoscoped. At bronchoscopy no obstructing lesions were identified and bronchial washings were negative for acid fast bacilli on stain and malignant cells on cytology. The patient was discharged in her prior state of health but with a persistent left upper lobe infiltrate on chest x-ray.

Case #2

A 20 year old male was admitted with a seven day history of fever, frontal headache, myalgia, arthralgia, stiff neck and skin rash. He denied drug abuse or exposure to ticks. On physical exam the temperature was 103.8°C, pulse 100 beats per minute, respiration 18 per minute and blood presure 138/88. A maculopapular skin rash was noticed on the back and thighs, the lungs were clear, the abdomen showed no organomegaly and the neck was supple. Laboratory data revealed a hemoglobin of 13.4 g/dl, hematocrit 38.8%, white blood cell count 12,000 with 81 segs, 4 bands, 11 lymphs, 3 monos and 1 eosinophil. A lumbar puncture was performed and the

*Address all correspondence to LeRoy F. Harris, M.D. at the above address.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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cerebrospinal fluid was clear with no red blood cells, 1 white blood cell, protein 38 mg% and glucose 69 mg%. Because of a clinical suspicion of Rocky Mountain Spotted Fever the patient was started on tetracycline hydrocloride two grams per day and made a rapid clinical improvement. When blood cultures drawn on admission were reported growing Neisseria species (confirmed as N. meningitidis group C by counterimmunoelectrophoresis), the patient was changed to penicillin G potassium 18 million units per day. Cerebrospinal fluid obtained at admission showed no growth.

DISCUSSION

N. meningitidis is an aerobic gram negative diplococcus which grows best on chocolate agar in the presence of 5 percent carbon dioxide. Use of Thayer Martin media is used for isolation of the meningococcus from sites of colonization or bacterial overgrowth. Human beings are the only known reservoir for N. meningitidis and the portal of entry for infection is the nasopharynx and upper respiratory tract. The three most important factors which determine if carriage of the meningococcus will progress to bacteremia and the resulting severity of the bacteremia are the immune status of the patient, the virulence of the meningococcus, and antecedent or concomitant viral infection.[5]

Wolf and Birbara described the clinical spectrum of meningococcal infections based on their experience at an army training center.[6] In the bacteremic case, the patient presents with an upper or lower respiratory infection or viral appearing exanthem which clears rapidly with or without antibiotic therapy. Blood cultures are reported as positive for N. meningitidis frequently after the patient has improved or is asymptomatic. Case #1 is an example of the bacteremic form of meningococcemia. The patient was admitted with pneumonia and positive blood cultures for N. meningitidis which presumably caused her pneumonia. She improved despite receiving inappropriate antibiotic therapy. Her ultimate recovery was associated with a change in therapy to an appropriate antibiotic.

The septicemic patient presents with the sudden onset of fever, chills and myalgia and soon develops a petecchial to maculopapular skin rash. Disseminated intravascular coagulation, shock and death may ensue and recovery requires appropriate antibiotic therapy and good supportive care. Metastatic seeding of the infection to the pericardium, heart valves, joints and lungs may occur. Case #2 exhibited a septic pattern although he recovered despite antibiotic treatment that was less than optimal.

The meningitic and meningoencephalitic presentation of meningococcal infection frequently involves children as well as closed populations such as military recruits. Fever, headache, vomiting and meningeal signs are seen and the sensorium varies from clear to cloudy to coma. Skin rashes and hypotension are absent.

An interesting and the least common variety of meningococcal infection is chronic meningoccemia. Fever, headache, maculopapular to petechial skin rash and joint pains appear in a continuous or intermittent fashion. The average duration of illness is seven weeks but may be as long as 10 weeks in cases complicated by meningitis or carditis. Diagnosis is made by blood culture and appropriate antibiotic therapy is curative.[7] This syndrome must be differentiated from recurrent episodes of meningococcal bacteremia associated with deficiency of complement.[8]

Several important complications of meningococcal infection exist. A recovery phase serositis manifested by fever and a variable combination of arthritis, pericarditis, pleuritis and skin rash appears between the 4th and 10th days of treatment. Cultures of blood, joint, pericardial or pleural fluid usually are negative and recovery ensues spontaneously. Clinically important disseminated intravascular coagulation is seen in 10 to 20 percent of reported cases of meningococcemia and myocarditis clinically expressed as arrhythmias and pump failure is found at autopsy in up to 80 percent of cases. Adrenal hemorrhage, or the Waterhouse-Friderichson syndrome, is a well publicized complication of meningococcal infection but acute adrenal failure rarely if ever results.

Therapy of meningococcal infection rests with early recognition and institution of appropriate antibiotic therapy and good supportive care. The drug of choice is intravenous penicillin 20 million units per day given in divided doses every two to four hours. For the penicillin-allergic patient, intravenous chloramphenicol four grams per day is administrated in divided doses every six hours. The duration of treatment is 10 to 14 days.[9]

Antibiotic prophylaxis with rifampin 600 mg. every 12 hours for four doses is indicated for close contacts of cases and include household members, sexual partners and closed populations such as college dormitories and military barracks. Immunoprophylaxis with a purified polysacchride antigen has been developed for group A and C meningococci.[9]

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RACHEL WEEPING FOR HER CHILDREN

By State Department of Pensions & Security

In the Bible there are several references to Rachel's weeping for her children. She would be comforted because they "were not." In Alabama there are Rachels weeping for their children because they "were not."

In August 1981, the Supreme Court of Alabama ordered an Alabama couple to return their adopted child to its natural mother. The child had been in the adoptive parents' home for nearly three years. The basis of the Court's decision was that the adopting parents had not followed the state law in adopting the child.

The opinion stated that noncompliance with Section 38-7-15, *Code of Alabama, 1975,* invalidated the adoption proceedings. The section of the Code in part reads as follows: "No person or agency shall bring or send any child into the state of Alabama for the purpose of placing him or procuring his adoption or placing him in any child-care facility, as defined herein, without first obtaining the consent of the department. . . ."

In another recent situation, an Alabama attorney arranged for a mother to come to Alabama from another state to have her baby. The attorney placed the child with the adoptive couple, who agreed to pay air fare, maternity costs and other expenses of the mother. In less than three months, the natural mother had filed through her attorney a petition to set aside her consent to adopt because erroneous information was included and request was made for return of child to mother.

A social worker "weeps" with an adoptive father as he relates his experience of securing a child independently and the natural mother's finding the child and the adoptive father's paying sums of money through the years to keep the child and the adoptive mother from being disturbed.

Then there is the adult adoptee who returns to the agency seeking information about her identity. Her parents told her she was placed by a doctor whom she located and who refused to give her information which she needs for medical reasons and which the agency does not have since she was never in the custody of a child-placing agency.

"Rachels are weeping because their children are not," and physicians, attorneys and social workers need to examine the elements of legal and psychological risks in adoptions consummated without the benefit of social services.

Many pregnant girls turn to their family physicians or attorneys instead of agencies; perhaps they do not know that agencies exist that would help them. Many of the pregnant girls deciding to place their children need counseling, but they feel under pressure from parents or intermediaries to relinquish their children and are left with unresolved guilt feelings and conflicts.

In their anxiety to receive a child into their home, adoptive parents are susceptible to the risks of harassment when the natural parents know the child's whereabouts. Adoptive parents are sometimes paying large sums of money and then may have to face the fact that the child may be born with a handicap or the mother may change her mind about placing the child. In privately arranged placements there is no judicial proceeding terminating parental rights and, thus, no guarantees of the adoptive parents' rights to security in their relationship to their child.

The Medical Association of the State of Alabama recognizes the value of sound adoption placement practice and some years ago adopted the following resolution:

"Whereas, The adoption of children into unrelated homes is of continuing and increasing interest to prospective foster parents, to the public generally, and to the Medical Association of the State of Alabama; and

"Whereas, Alabama law since 1931 has established legal procedures for adoption so as to safeguard the children as well as the natural and foster parents; and

"Whereas, Recognition must be given to the fact that physicians occupy, in many instances, strategic positions when children are in danger of being deprived of parental care and support by virtue of the fact that (1)

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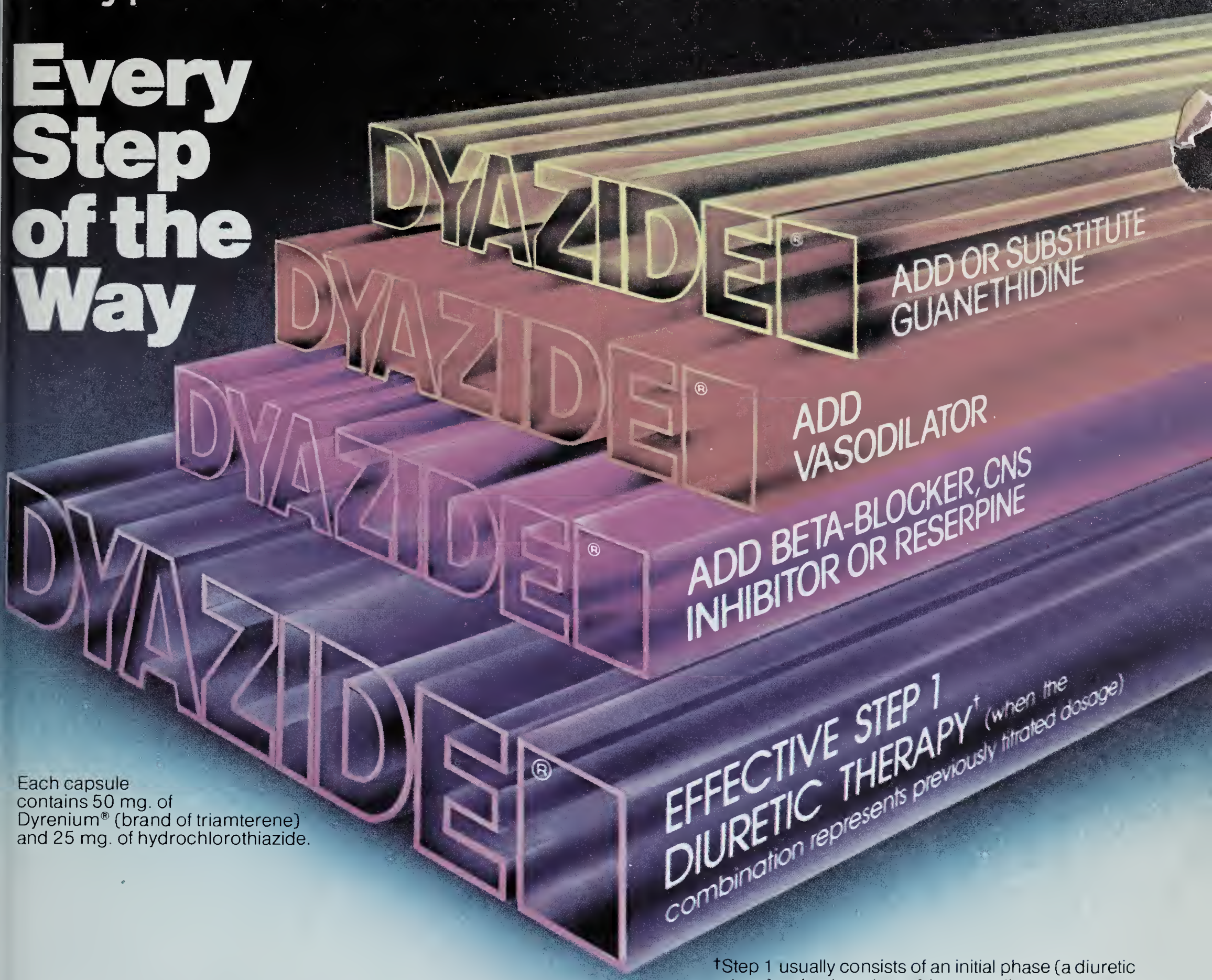

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Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

SK&F CO.
a SmithKline company
Carolina, P.R. 00630

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This free brochure and a walk through your house could cut your home energy use by 25%.

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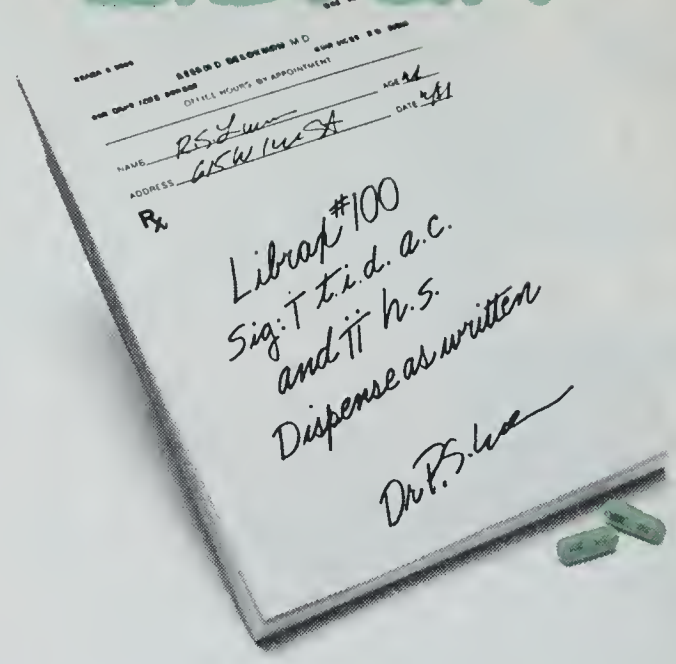
Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE®

Roche Products Inc.
Manati, Puerto Rico 00701

Irritable BOWEL SYNDROME*

Artist's concept of myoelectrical slow waves of the colon which seem to determine the frequency of colonic motor activity.

A visible difference in myoelectric rhythms of the colon

Studies reveal an increased frequency of 3-cycles-per-minute slow wave basic electrical activity in the colons of patients with IBS—a significant difference in basic colonic rhythm patterns from normal subjects.[1,2] These findings suggest a physiological basis for the spasm and hypermotility characteristic of IBS. The role of severe anxiety in triggering or aggravating such symptoms has long been recognized. Consequently, treatment should focus on both aspects of the problem.

Librax: A logical choice for patients with IBS

Logical, because the antimotility-antispasmodic actions of the Quarzan®(clidinium bromide/Roche) component of Librax can help to relieve the distressing abdominal symptoms associated with IBS.*
Logical, because the antianxiety actions of the Librium® (chlordiazepoxide HCl/Roche) component can help to reduce the excessive anxiety that can contribute to IBS flare-ups.

References: 1. Sullivan MA, Cohen S, Snape WJ: *N Engl J Med* 298:878-883, Apr 20, 1978.
2. Snape WJ *et al*: *Gastroenterology* 72: 383-387, Mar 1977.

Specify Adjunctive **Librax®**

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

ROCHE®

*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.

for Knotts in the night

Prescribe new formula

Quinamm*

(quinine sulfate tablets)

each tablet contains quinine sulfate 260 mg

Specific therapy for painful night leg cramps

Merrell Dow

*Trademark of MERRELL-NATIONAL LABORATORIES Inc.,
Cayey, Puerto Rico 00633

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

Quinamm™
(quinine sulfate tablets)

CAUTION: Federal law prohibits dispensing without prescription.

BRIEF SUMMARY

INDICATIONS AND USAGE
For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS
Quinamm may cause fetal harm when administered to a pregnant woman. Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g.) for attempted abortion. In about half of these reports the malformation was deafness related to auditory nerve hypoplasia. Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes. In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys. Quinamm is contraindicated in women who are or may become pregnant. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency.

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use. Recovery usually occurs following withdrawal of the medication and appropriate therapy.

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever.

WARNINGS
Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism. Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision; however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin.

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine. Quinamm should be stopped immediately if evidence of hemolysis appears.

If symptoms occur, drug should be discontinued and supportive measures instituted. In case of overdosage, see OVERDOSAGE section of prescribing information.

PRECAUTIONS
General
Quinamm should be discontinued if there is any evidence of hypersensitivity. (See CONTRAINDICATIONS.) Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken. Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form. Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy.

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine. (See Drug Interactions.)

Drug Interactions
Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration. Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly.

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

The effects of neuromuscular blocking agents (particularly pancuronium, succinylcholine, and tubocurarine) may be potentiated with quinine, and result in respiratory difficulties.

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity.

Drug Laboratory Interactions
Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used.

Carcinogenesis, Mutagenesis, Impairment of Fertility
A study of quinine sulfate administered in drinking water (0.1%) to rats for periods up to 20 months showed no evidence of neoplastic changes.

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test. Intraperitoneal injections (0.5 mM/kg.) were given twice, 24 hours apart. Direct *Salmonella typhimurium* tests were negative; when mammalian liver hemogenate was added, positive results were found.

No information relating to the effect of quinine upon fertility in animal or in man has been found.

Pregnancy
Category X. See CONTRAINDICATIONS.

Nonteratogenic Effects
Because quinine crosses the placenta in humans, the potential for fetal effects is present. Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown. Quinine in toxic amounts has been associated with abortion. Whether this action is always due to direct effect on the uterus is questionable.

Nursing Mothers
Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts).

ADVERSE REACTIONS
The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage. (Individual or multiple symptoms may represent cinchonism or hypersensitivity.)

Hematologic: acute hemolysis, thrombocytopenic purpura, agranulocytosis, hypoprothrombinemia.

CNS: visual disturbances, including blurred vision with scotomata, photophobia, diplopia, diminished visual fields, and disturbed color vision, tinnitus, deafness, and vertigo, headache, nausea, vomiting, fever, apprehension, restlessness, confusion, and syncope.

Dermatologic-allergic: cutaneous rashes (urticarial, the most frequent type of allergic reaction, papular, or scarlatinal), pruritus, flushing of the skin, sweating, occasional edema of the face.

Respiratory: asthmatic symptoms.

Cardiovascular: anginal symptoms.

Gastrointestinal: nausea and vomiting (may be CNS-related), epigastric pain.

DRUG ABUSE AND DEPENDENCE
Tolerance, abuse, or dependence with Quinamm has not been reported.

OVERDOSAGE
See prescribing information for a discussion on symptoms and treatment of overdose.

DOSAGE AND ADMINISTRATION
1 tablet upon retiring. If needed, 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring.

After several consecutive nights in which recumbency leg cramps do not occur, Quinamm may be discontinued in order to determine whether continued therapy is needed.

Product Information as of October, 1980

Licensor of Merrell:

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

Direct Medical Inquiries to

Merrell

DOW

MERRELL DOW PHARMACEUTICALS INC.
Subsidiary of The Dow Chemical Company
Cincinnati, OH 45215, U.S.A.

1-8137 (Y437C)MNQ-699

the natural mother may have made the initial contact with the physician in her time of stress and discouragement; and (2) the physician may have delivered the child; and (3) persons desiring to adopt a child may have made the original contact with their physician; and

"Whereas, It is recognized that the State law makes specific provisions for authorized agencies staffed by social workers to render service to natural parents, to children in danger of being deprived of parental care and support, and to prospective foster parents; and

"Whereas, As important as the role of the physician is, his profession does not equip him to replace the role of the social worker, therefore be it

"Resolved, That the Medical Association of the State of Alabama recommends (1) that all County Medical Societies carefully scrutinize any practice leading to the placement or referral of children for adoption by physicians; and (2) that individual physicians use their influence to acquaint their patients to whom they provide professional service with the procedures of adoption as prescribed by law; and be it further

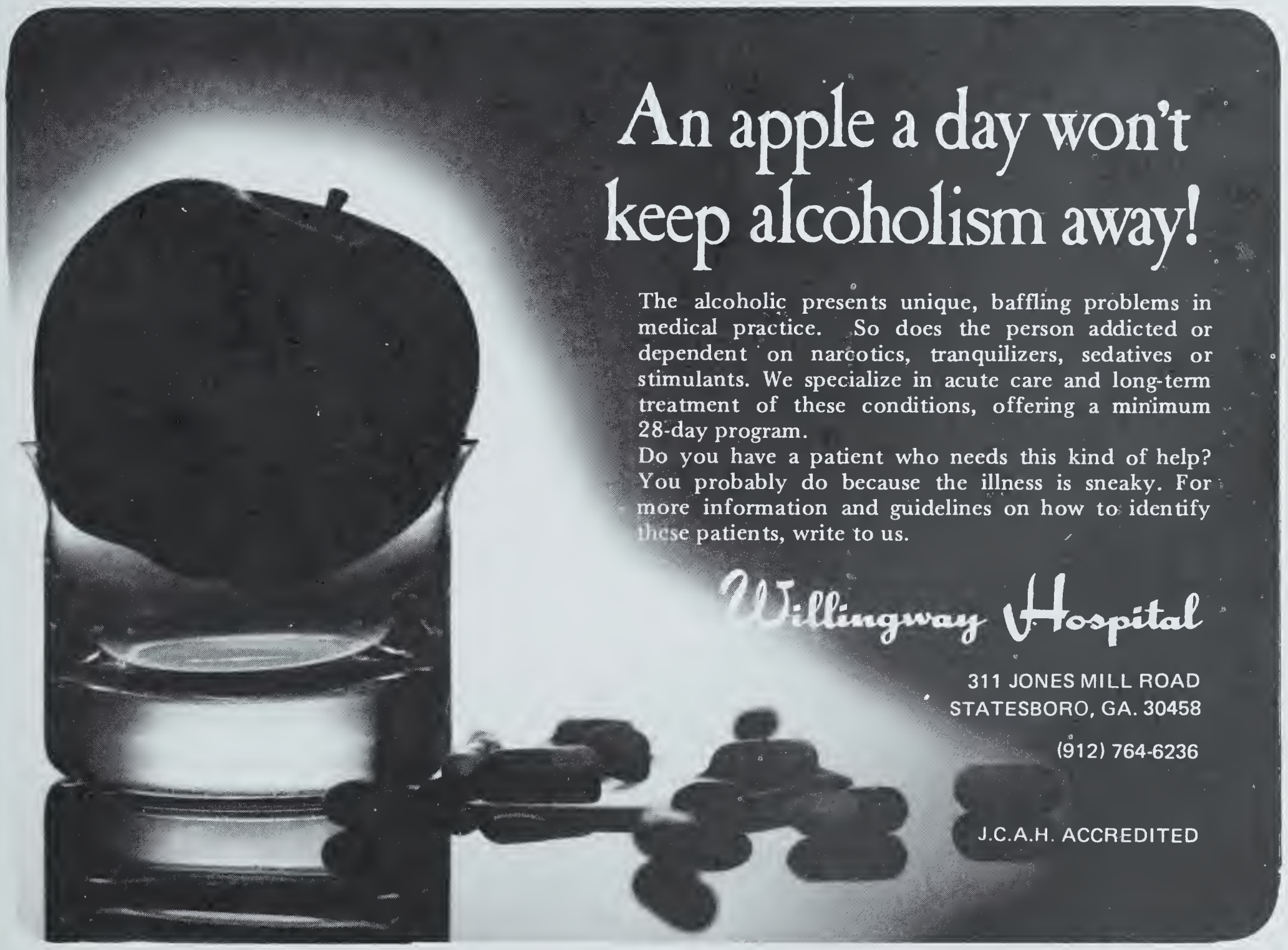
"Resolved, That a copy of this resolution be mailed to the presidents of all County Medical Societies, to the State Health Officer, to the probate judges in the sixty-seven counties, and to the Commissioner of the State Department of Public Welfare."

In the adoption program of Alabama, the physician has a major role in decisions with reference to determining when infants and older children are "ready" to be placed for adoption. Upon the advice of physicians, placement plans are sometimes delayed so that the doctor can make further observations and diagnostic tests.

The careful observation of the doctor and consultation with the social worker enable the agency to proceed with more confidence in placement of children. When physicians participate in adoption placements without the involvement of a social agency, their highly significant role in adoption and service to their patient is negated.

Particular sections of the *Code of Alabama, 1975,* relate to the role of the physician in adoption. They are as follows:

Section 22-21-31. Practice of medicine, etc., not authorized; child-placing.
Nothing in this article shall be construed as authorizing any person to engage in any manner in the prac-



tice of medicine or any other profession nor to authorize any person to engage in the business of child placing. Any child born in any such institution whose mother is unable to care for such child or any child who, for any reason, will be left destitute of parental support shall be reported to the state department of pensions and security or to any agency authorized or licensed by the state department of pensions and security to engage in child placing for such service as the child and the mother may require. . . . . .

Section 26-10-8. Advertisement as to adoption by persons, organizations, etc., not licensed by department of pensions and security.

It shall be unlawful for any person or persons, organizations, hospitals or associations which have not been licensed by the state department of pensions and security to advertise that they will adopt children or place them in foster homes or hold out inducements to parents to part with their offspring or in any manner knowingly become a party to the separation of a child from its parent, parents or guardian except through the commitment of a court having jurisdiction.

Adoption is an experience involving the emotions of many people. The goal of all of us should be the protection of the child first, but also of the natural parents and the adoptive parents.

The cooperation of social workers, physicians, attorneys, and several other professions is needed, as no one person or profession can take the responsibility alone to prevent "Rachel Weeping for Her Children."

SCORE ONE FOR THE THE VICTORIANS

Editor, The Journal

As a female physician and an ardent admirer of Dr. Claude Brown, I must take issue with Dr. Lynn Anderson Jetton's letter in Volume 51, No. 3 regarding Dr. Brown's delightful article in Volume 51, No. 1.

Being a native Alabamian and third generation physician, I am thankful that I grew up before the days of ERA when women enjoyed being women and men enjoyed being men. I have been nurtured and encouraged over the years by many patronizing, very supportive MEN including my father, grandfather and Dr. Claude Brown. I feel so very sorry for these miserable Women's Libbers with chips on their shoulders, who cannot enjoy their profession because of their sex.

Long live Dr. Claude Brown and my other Victorian, patronizing male colleagues.

Betty Ruth Speir, M.D.
UA Class of 1963

Associate Clinical Professor
of OB/GYN
The University of South Alabama
College of Medicine

CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by S. pneumoniae (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Graup A beta-hemolytic streptococci and staphylococci, nanpenicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug shauld not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness af therapy and susceptibility of bacteria. Therapy may be instituted priar to results of sensitivity testing.
Contraindications Contraindicated in individuals with history af an allergic reactian to penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility ar harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal repraduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.
Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactians reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdaminal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with ather penicillins are anemia, thrambocytopenia, thrombacytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discantinuation af therapy.
As with other semisynthetic penicillins, SGOT elevations have been reparted.
As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptamatic or until bacterial eradicatian is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recammended to guard against risk of rheumatic fever ar glomerulonephritis. In chranic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infectian may require treatment for several weeks.
Cyclacillin is not indicated in children under 2 manths of age.
Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with variaus degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced dases)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg ta 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

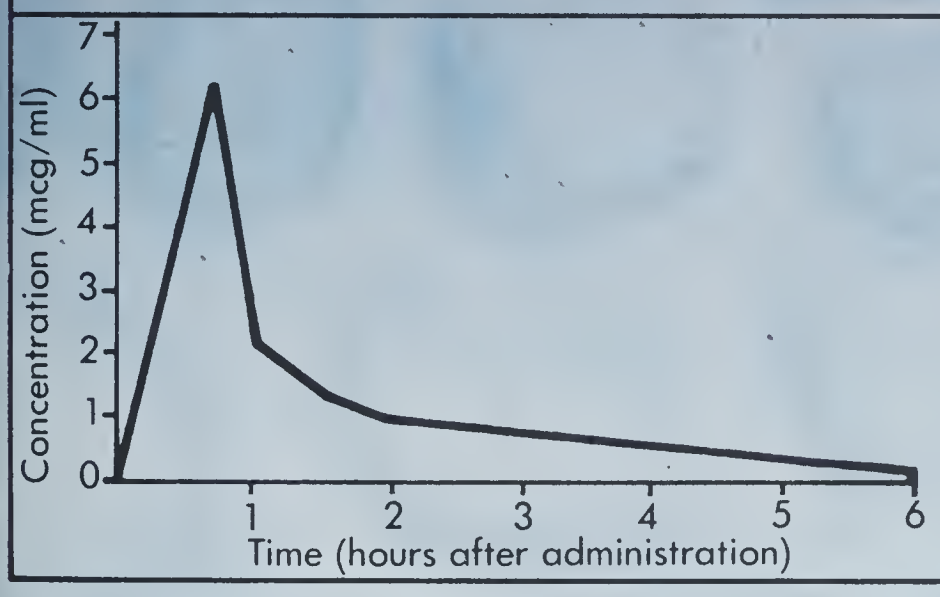
*Dosage should not result in a dose higher than that for adults.
†depending on severity

Wyeth Laboratories
Philadelphia, Pa. 19101

Half the dose is absorbed in 9 minutes!

compared to 32 minutes for ampicillin.*

Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based an T^{a} ½ values far single oral dases af 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data an file, Wyeth Labaratories.

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Wyeth Laboratories · Philadelphia, Pa 19101

Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

CYCLAPEN®-W
(cyclacillin)

250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

more than just spectrum

NEW NAME

Classified Advertising

EMERGENCY ROOM PHYSICIAN SOUTH GEORGIA Physician owned group needs additional full-time emergency physician. Contract with medium size hospital; good community; excellent place to raise children; salary negotiable; early partnership. P. O. Box 1900-C, Box A, Montgomery, Alabama 36197

ATTENDING STAFF PHYSICIAN, Emergency Department. Excellent opportunity for experienced/interested physician in the field of Emergency Medicine. University Medical Center teaching hospital is seeking a physician for clinical and teaching duty in the Emergency Department. Superb staff support provided. Role includes direct patient care, supervision of housestaff during rotations in Emergency Department and interaction with various specialty services. Will also be involved in planning and development of clinical research programs in Emergency Medicine. Should be board eligible/certified in Internal Medicine. Send resume to Frederic G. Ransom, M.D., Medical Director, University of Alabama Hospitals, Emergency Department, 619 South 19th Street, University of Alabama in Birmingham, Birmingham, Alabama 35233. University of Alabama Hospitals is an Affirmative Action/Equal Opportunity Employer.

PHYSICIAN'S OFFICE AND PRACTICE FOR SALE. Available immediately. General Practice in Tuscaloosa, Alabama, for thirty-two years. Retiring because of illness. Ideally situated and quality practice. Fully equipped. phone No. 1-205-553-8017 or 1-205-758-0011. Judson D. Dowling, M.D., 86 The Highlands, Tuscaloosa, Alabama 35404.

PEDIATRICIAN—Wanted to join Board Certified, established practicing pediatrician with extensive practice in general pediatrics, pediatric allergy, consulting pediatrics. Outstanding geographic, economic and professional opportunity. Minimal night & Weekend work due to cooperative arrangements. Salary negotiable, early partnership or purchase of practice.

FAMILY PRACTICE PHYSICIANS needed in Southwest Alabama town. City population approximately 5,000, health service area approximately 30,000. Excellent location for outdoor recreational activities. Accessable to metropolitan areas and Gulf Coast.

NEEDED—Used Ritter chair/table, large autoclave, O. R. lights and scrubsink, contoured blood donor chair, treatment/drug cabinets and many misc. items. Contact Dr. Joseph Hauser, 4350 Woodley Square, No. 3-213, Montgomery, AL 36116.

NEEDED IMMEDIATELY: ONE OR TWO FAMILY PRACTITIONERS/GENERAL PRACTITIONERS and one general surgeon for excellent practice opportunity in a progessive rural Alabama community. Beautiful location, ideal for family living and outdoor recreational activities. Substantial guarantee along with competitive financial assistance plan. Write Healthcare Management Group, Suite 112, Three Riverchase Office Plaza, Birmingham, Alabama 35244 or telephone Margaret Carter collect at (205) 988-4488 for more information.

FAMILY PHYSICIAN to join 2-man family practice next door to 300 bed hospital. Excellent privileges. Salary guaranteed with fringes and incentives. Partnership at end of 2nd year. Contact E. P. Dickerson, M.D., Westside Family Physicians, Suite 5500, 2010 59th St. W., Bradenton, FL 33529. (813) 792-2211.

ALABAMA, METROPOLITAN BIRMINGHAM AREA, immediate practice opportunities for FP, OB/GYN, Pediatrician, Internist (General, pulmonary, cardiology) and Orthopedist to serve growing area. Excellent professional and economic opportunity. Enjoy country atmosphere with easy access to medical school; excellent family environment and abundant recreational opportunities. Office space available in clinic adjacent to hospital. Full range of competitive financial benefits. Must be residency trained, board certificate/eligible. Send C. V. to Meg Carter, Healthcare Management Group, Suite 112, Three Riverchase Office Plaza, Birmingham, Alabama 35244, or call (205) 988-4488.

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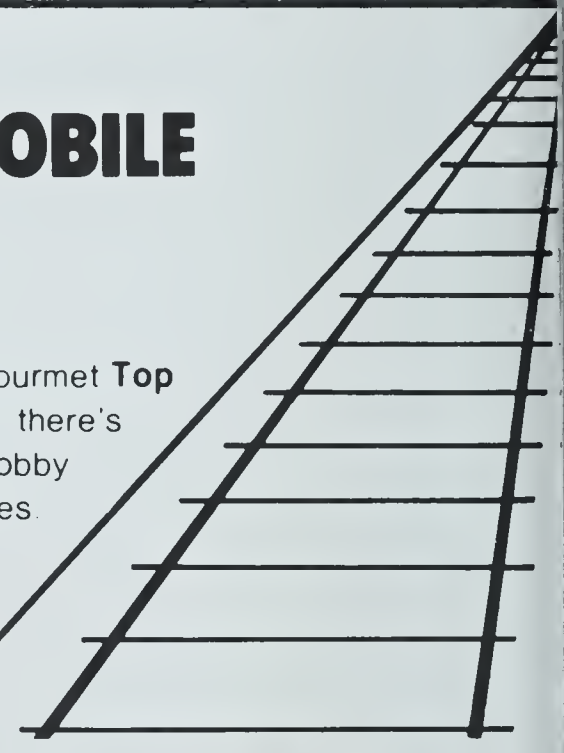

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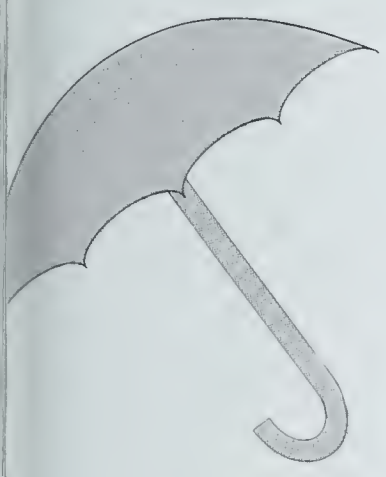

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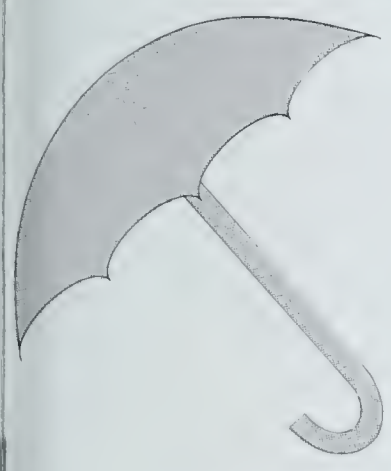

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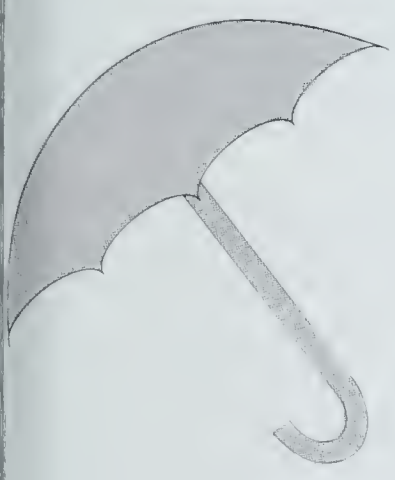

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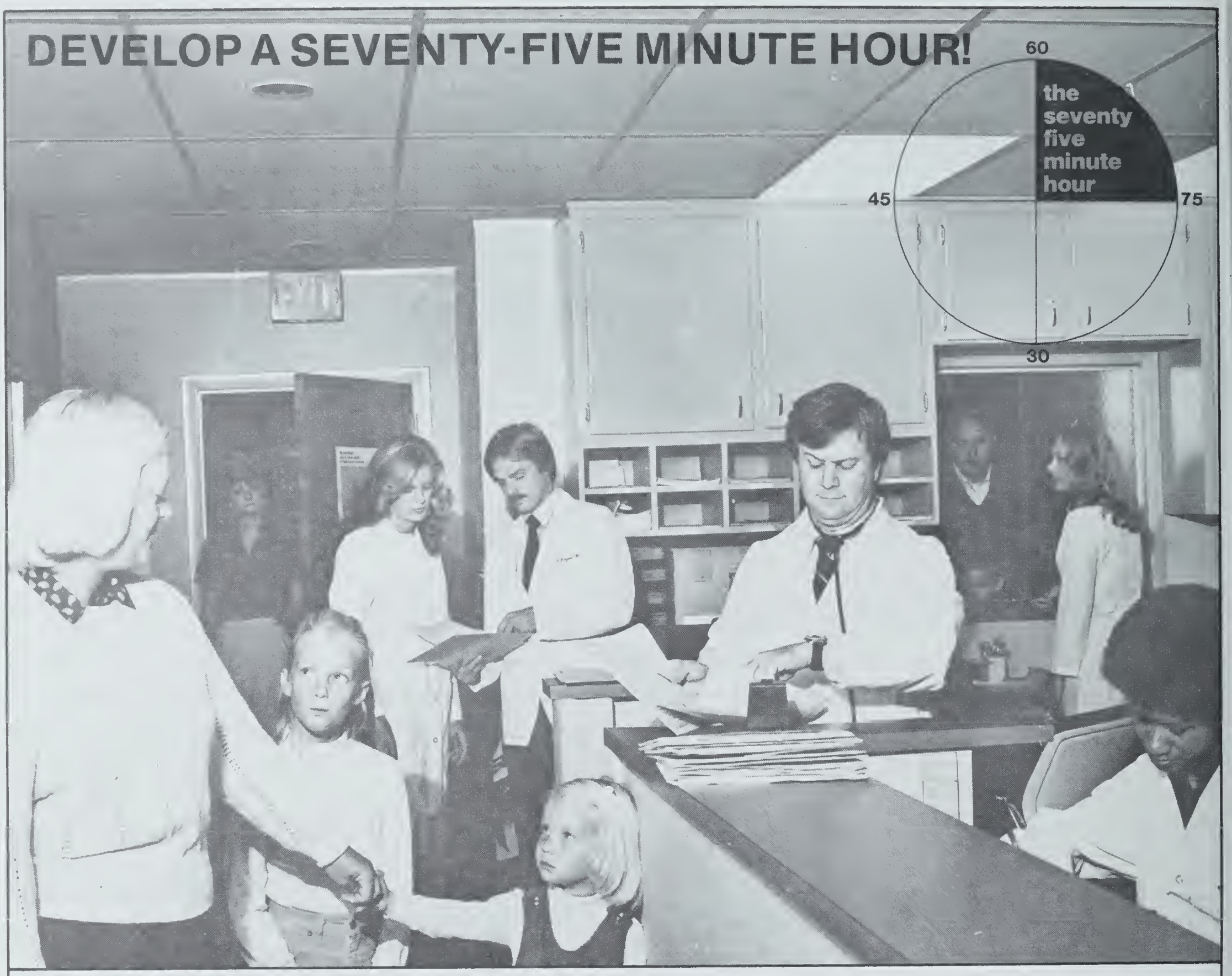

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The Gift of Life

As Christmas approaches, we turn our thoughts to greeting friends and relatives, to reminiscing of days gone by and to thanking God for our existence. It is a time to make merry and to share the fruits of our labor. Most of us have been searching for weeks for the perfect gift for everyone on our list. What a wonderful feeling when we know that gift was received with the mutual love that it was given.

There are some very special gifts needed so desperately by thousands and can be given by all of us. These gifts do not cost money but it takes a compassionate and unselfish heart to give them.

We have the power with our gifts to enable a person suffering from kidney disease, blindness or other abnormalities to receive a miracle of medical science—Transplantation. Henry Van Dyke said in a poem: **Keeping Christmas—**"the only good reason for existence is not what you are going to get out of life, but what you are going to give life."

Last year there were 10,000 patients who needed kidney transplants and only 5,000 were obtained. The Organ Bank reported 119 kidney transplants done in Alabama last year, two-thirds of kidney transplants are cadaveric and one-third are from living relatives.

There are 71 people on the waiting list for a donor at the present time. Unfortunately, some of these people will not live long enough to receive their transplant. The Organ Bank is also setting the wheels in motion to have hearts available for transplants in the next year.

The Alabama Eye Foundation reports 175 cornea transplants in 1980-81. Only 20% of the patients who need corneas get them—80% remain blind. Did you know that if one person donates their eyes tonight two people will see the sun rise tomorrow? In approximately 4 months, these people will have normal vision. The sclera (white part of eye) is used in cosmetic surgery and to restore ear drums. Up to 90% of hearing can be regained.

The Auxiliary has chosen The Organ Donor Program as the Community Health project for the 1981-82 year. Mrs. B. R. Mosley is our Community Health chairman and she is already busy getting all available information out to county leaders.

To become an organ donor is very simple. You may ask to have it put on your drivers license or you can call the Organ Bank at 934-6330 and the Eye Foundation at 871-EYES. Both will be happy to send the information along with a legal Donor card.

"Give my sight to the man who has never seen a sunrise, a baby's face or love in the eyes of a woman. Give my heart to a person whose own heart has caused nothing but endless days of pain. Give my blood to the teen-ager who was pulled from the wreckage of his car, so that he might live to see his grandchildren play. Give my kidneys to one who depends on a machine to exist from week to week. Take my bones, every muscle, every fiber and nerve in my body and find a way to make a crippled child walk.

"Explore every corner of my brain. Take my cells, if necessary, and let them grow so that, someday, a speechless boy will shout at the crack of a bat and a deaf girl will hear the sound of rain against her window.

"Give my sins to the devil. Give my soul to God.

"If, by chance, you wish to remember me, do it with a kind deed or word to someone who needs you. If you do all I have asked, I will live forever."[1]

Mary Julia Lee

[1]Robert N. Test in Cincinnati Post.

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5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
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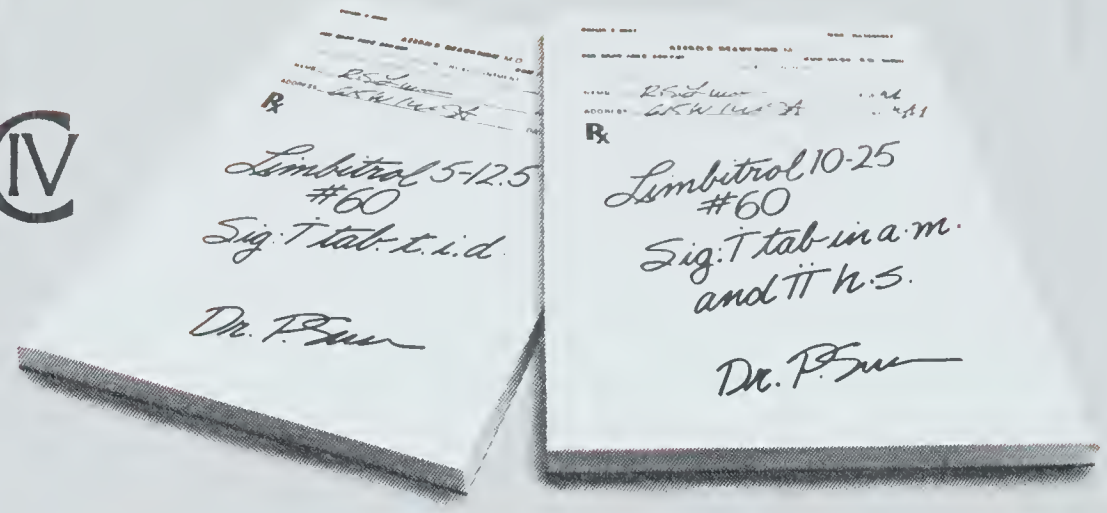

In anxious depression,

SPECIFIC FOR THE NONPSYCHOTIC PATIENT

Fits the picture of anxiety/depression correlation

Most patients with a mood disorder have a mixture of anxiety and depression. One clinician[1] found a correlation of 0.7 in anxiety and depression scores; another[2] has estimated that 7 of 10 nonpsychotic depressed patients are also anxious. For the dual symptomatology of anxious depression, Limbitrol provides dual medication.

More appropriate for the nonpsychotic depressed and anxious patient

Limbitrol contains both amitriptyline, specific for symptoms of depression, and a benzodiazepine, specific for the symptoms of anxiety. Thus it is a better choice than other dual agents for anxious depression that contain a phenothiazine, a class of antipsychotic drugs less specific for anxiety and now generally avoided in nonpsychotic patients.[2,3]

Avoids the risk of tardive dyskinesia carried by the phenothiazine combinations

The causal relationship between the phenothiazines and other extrapyramidal side effects, including tardive dyskinesia, is well established. In contrast, the reported incidence of these adverse reactions with Limbitrol or either of its components is rare.

References: 1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970. **2.** Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* edited by Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **3.** Baldessarini RJ, Tarsy D: Tardive dyskinesia, in *Psychopharmacology: A Generation of Progress,* edited by Lipton MA, DiMascio A, Killam KF. New York, Raven Press, 1978, p. 999.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

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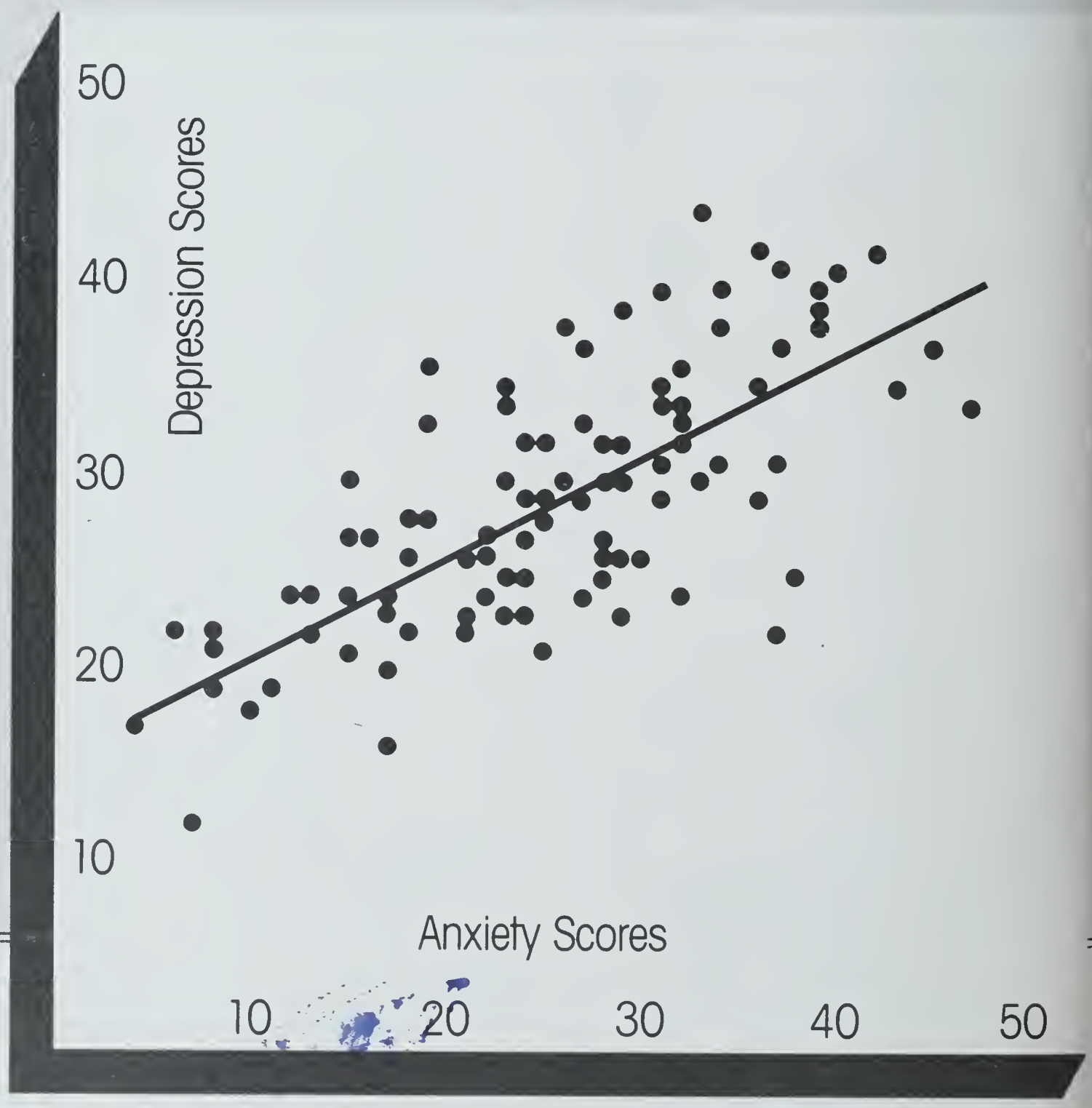
MORE DEPRESSION MEANS MORE ANXIETY...



The graph illustrates the close correlation between depression and anxiety derived through the MMPI and the Taylor Manifest Anxiety Scale in 100 nonpsychotic psychiatric patients. The Coefficient of Correlation is 0.7. As depression increased, so did the anxiety levels.
—Adapted from Claghorn J[1]

A key reason why

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1. Claghorn J: *Psychosomatics 11*:438-441, Sept-Oct 1970

Please see summary of product information on inside cover.

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JOURNAL

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VOL 51, NO. 6, DECEMBER, 1981

DENTAL
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THE PATIENT THINKS HE HAS HEART TROUBLE...

...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® (IV)

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

ROCHE®

Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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On The Cover

MEDICINE IN THE MIDDLE AGES

This 500-year-old woodcut from the Reynolds Historical Library, Lister Hill Library of the Health Sciences, UAB, depicts the European physician of the late Middle Ages compounding his own options. The state of the art then was such that diagnosis and treatment were often curious combinations of alchemy and sorcery as well as science.—MASA photo from Reynolds collection.

Now or Never

The end of an old year and the beginning of a new is always a time for reflection on the past and contemplation of the future. Spare me if I indulge in that age-old weakness.

Certainly the most momentous development during 1981 was the attempt to reorder the nation's economy. In trying to reverse the tides of almost half a century of drift toward the welfare state, President Reagan had the instincts and the courage of a riverboat gambler, to use the descriptive phrase of one of his lieutenants, Senator Howard Baker.

No one, least of all the nation's economists, are exactly certain how this new economics will work out in either the near term or the long term. There is sincere doubt expressed by many in his own party, and certainly by Wall Street, that such a sudden cutoff of the federal dole may have untoward effects on an economy built of ever-increasing federal spending.

Surely the persistence of high interest rates was not a failing mark. As the President said, you could hardly expect the results of decades of federal excess to be corrected in weeks. Most conservatives who expressed apprehensions did so because they feared that the experiment would not be carried far enough, that the deficit brought on in part by the President's tax cut, but mainly from the spending excesses of recent years, would not be reduced to a size small enough to achieve the objective.

Perhaps in 1982 there will be a clearer view of the lasting effects of the President's attempt to return the national economy to something closer to sanity.

Virtually no one has escaped the cruelest tax of them all, inflation. From the modest pensioner to the very rich, all have paid a price. The little man spends a far higher percentage of his income on the necessities of life—all skyrocketing upward in price—than the man whose principal worry is the high cost of luxury yachts.

Still, it is a gamble. Keynesian economics has had such a hold on Washington and the nation for so long the President's cures could send the country into shock, as Senator Baker implied and others privately fear. No one really knows. But the turn-around attempt had to be made. Voters seemed to have said that in the last general election.

At the very least, the new sense of frugality that has been generated by the attempts to halt the treasury drain is of great value in itself. Too many years of easy-come-easy-go living have infected Americans at all levels of income and interest. The belief that there is no tomorrow, so alien to a young country that had always planned for the future, seems to have been dealt a timely blow.

None of which is to say that physicians will be spared some of the effects of the new austerity. For one thing, the government supply of money into the health care pipeline has been squeezed and will likely be restricted even more.

But doctors should rise above the wail heard abroad in the land as each interest group's ox is gored by cutbacks. The best austerity program, like the best tax, is always the one somebody else had to endure. That is only human nature.

But 1982 is a congressional election year. It will be more than surprising if the old practitioners of tax & spend are not doing business at the same old stand, trying to exploit the many individual grievances that may exist at that time, resulting from a bold attempt to return the nation to fiscal sanity.

It is incumbent on all Americans, I believe, to ignore the siren song of those who would take us back to the bad old days that got us into this fix. I hope that as 1982 moves along Americans will bear whatever ills they have and tell Washington to keep trying to refloat the ship of state. The alternative, it appears, is ruin.

Best wishes for a challenging New Year.

S. Lon Conner
Executive Director

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J. Kendall Black, Jr., M. D.
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PRESIDENT'S PAGE

The Pogo Principle

As I have made my appearance and presentations at the various county societies throughout the state and have been exposed to the multiplicity of problems that relate to the various areas and groups within the state, I am coming more and more to the conclusion that we as physicians (if we are not careful) will very rapidly demonstrate what I call the Pogo Principle.

That principle is namely this: we have met the enemy and he is us.

If we are not careful, we are going to fall victim to an ancient military principle of divide and conquer. Except in our case we will divide ourselves so that we shall all be conquered.

To list just a few of the dichotomies that are developing I would simply point out to you the inequalities of the rural physician when compared with those of his urban counterparts; the specialist worries relative to actions taken by the non-specialist whose training may or may not be commensurate with the activity; the non-surgical specialist who has been up all night caring in a cognitive way for the patient, is frustrated by the apparent luxuries enjoyed by the invasive physician who has reported to the operating room in the early morning after a good night's sleep. The independent practitioner fears that the actions of the multi-specialty or pre-paid group will rapidly eliminate his independence. The private practitioner worries that the academicians perceived ability will diminish his patient load. The old doc in town who has been seeing the same patients for years is frustrated by the apparent unfeeling and inconsiderate attitude of the new physician in town. Those who would demand the true free marketplace functions of medicine and fear desperately the over-regulation of the profession have failed to recognize that we as a profession have been re-miss in our own self-regulation in many cases.

As a result of these and many other dichotomies we are seeing several things happen in the profession of medicine. To me there is a growing apathy and non-participation of our membership. The feeling is rapidly developing that we should let George do it. Yet at the same time even in the areas of leadership I find that there is a tendency toward top-heavy governing concept to the exclusion of participation by the membership. This obviously fuels the non-participation and apathy effect.

As I have pointed out in this column before, we represent a small fragment of the population yet we are responsible for the entire health of the population. While it is entirely logical given the Plethora of scientific information available to the practitioner of medicine today that fragmentation into scientific groups for the dissemination of knowledge is logical, I do not believe that there is any way that one can justify fragmentation of our overall goals and aims. There has to be a single umbrella organization that represents the over-all general interest of the medical profession in these United States and this State of Alabama.

We have all been medical students and we are all doctors of medicine first. We then have become specialists and practitioners in the various locations within this country. Our common goals are still to practice the best medicine we can in the setting we chose and for the patient's we select. We must once again speak to and communicate with each other for the common good.

/Kendall

J. Kendall Black, Jr., M.D.

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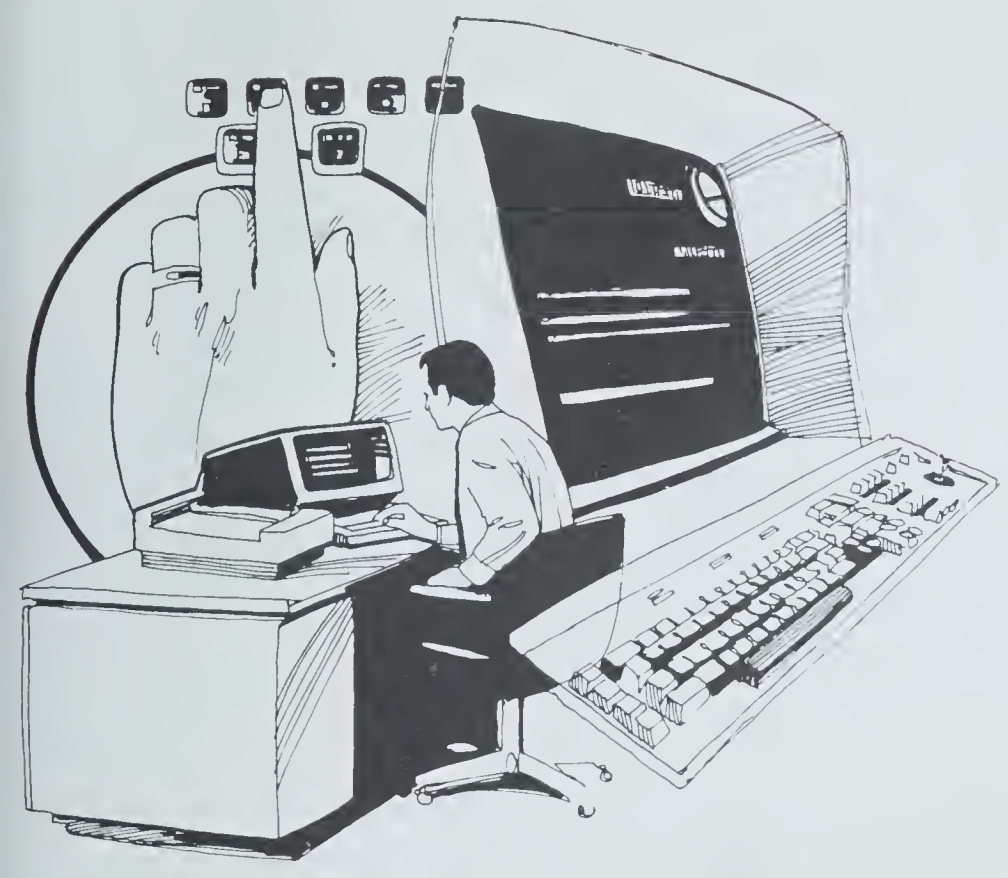


COMPUTERS IN THE PHYSICIAN'S OFFICE

By Debbie Hunter, CMA

This article is an excellent overview on the use of computers in medical offices and provides much practical information and tips to those who are considering this technology for their offices.

Debby Hunter is Medical Assistant to Durwood Bradley, M.D., Birmingham, and has had extensive professional experience in all aspects of medical office management. She is President of the Alabama Society of the American Association of Medical Assistants.

George Oetting, Ed.D.
Director of Education

As each era has claimed its own description of the age, it seems only fair to appropriately name this era as the "Age of the Computer." Data processing is really no longer done anymore, it is now called "information processing." The technology involved in this processing system has developed to the point that practically anyone can now own and operate a computer.

Because of the great strides made in industry upon implementation of a computerized system, it is not surprising that the medical community now recognizes the benefits to be gained from such a system. In the medical practice everyone is seeking the perfect formula, that when worked correctly, will provide the appropriate signals indicating when and if to computerize. Suddenly the physician begins to seek advice and *everyone* appears to be an expert in the area, from *Playboy* and *McCall's* to the teenager down the street. Conversation in the Doctors' Lounge has now taken on an added dimension from comparing patient reactions to comparing "hardware" and "software" applications.

At the same time, those special people chosen to work for these physicians swap horror stories about how to survive during the transition period. The decision to computerize and then the process of selecting the right system to meet the established needs is indeed tremendous and requires a great deal of research and planning. The following is a brief guideline to assist those who are about to begin this process and is written in an effort to pass on what others have learned in what some might term "the hard way"!

The first computers were located in government buildings and in 1950 there was a grand total of 15 computers in existence. These early computers required a strictly controlled environment with sufficient air conditioning for cooling purposes and specially designed vacuum cases for housing the computer.

In 1954 the business community began developing computers for purposes of inventory control, processing orders and performing tasks too large for calculators. In the late 60s the small computerized calculators could be bought for $10. Technological strides in the development of memory accessories has brought the cost of the small memory chip from $375 in 1975 to $13.95 today. These advances have brought us to the present age where we see a tremendous proliferation in computers.

As the equipment, or "hardware," evolved to its present standard, so too did the programs or "software." Software was first developed to perform those industrial tasks mentioned previously. When the medical community began expressing an interest in computerization, these industrial programs were simply adapted to the medical office situation. Unfortunately, these early programmers were unfamiliar with the basic administrative processes of the medical practice, such as third party billing and the way in which charges were incurred.

Because initial medical applications were not successful in meeting the specialized needs of the medical office, they created an unfavorable response in this area of computerization. It was not until recently that medical software applications have been written and successfully implemented in the medical practice.

Today there are three ways in which a computer may be utilized in the medical office—Batch, Time-share and Live. Batch billing involves collecting the data and send-

ing it to a service bureau where the information is keyed into the computer and whatever services the office required are done at the service bureau and returned to the physician's office for processing. The turn-around time on this process is usually two days, therefore a current status report is often difficult to obtain.

These service bureaus have two types of charges: a charge for designing the program and one for implementing the program. The average monthly cost for 500 active accounts for a major city in Alabama is approximately $375.00 per month. The more complicated and lengthy the reports, the higher the program costs will be.

Time-sharing offers its customers computer power much as an electrical utility offers electrical power. A terminal device (CRT) is installed in the medical office and is connected to a main computer via telephone lines. The medical office personnel enter data into the terminal which transmits the data to the main computer. The turn-around time is approximately 10 seconds.

Charges are based on a rental fee and the amount of computer time used, with additional charges if supplemental programs are requested. The average cost of this service for a similarly sized practice in the same location is $925 per month with a one time only conversion charge of $600.

Advantages in time-sharing are primarily in upkeep as the software and hardware are the total responsibility of the center providing the service.

Disadvantages in this system have been found in lack of speed for the larger programs and some offices have complained of lost data in communicating through the telephone lines. There is also a risk of breaches in confidentiality with this mechanism since other customers of the time-sharing system could gain access to a physician's records simply by placing the correct code into the terminal. Medical office files must be integrated into the system during a "transition period," a time when both manual and computer systems are employed simultaneously, and this may take 1-6 months to complete.

Live computing involves maintaining a microcomputer within the medical practice and also requires the same transition period as the time-share system. Many offices have delayed their decision to purchase a computer and utilized the time-sharing service only to undergo a second transition period one to two years later.

For a fee, some time-sharing agencies will convert the files for the physician but this is often a costly proposition. The purchase of a computer involves buying both hardware and software, and the cost of maintenance on each. These items can be contained in a single package or each can be purchased separately from various vendors. Although the initial purchase price of a computer appears high, the actual costs prorated over five years can be less than time-sharing.

The decision on which of these systems is the best for each office depends on a number of variables that will be discussed below. The various reasons why any type of computer system is appropriate can be narrowed down to two: either the physician "needs" one or he "wants" one.

"Needing" a computer is probably the worst reason for considering the purchase of a computer. An office that finds manual system can no longer maintain the volume of work or growth of the practice is already in a chaotic state and this is certainly not the best time to incorporate a computer system.

To quote Daniel K. Harris, Assistant Director of the AMA Division of Medical Practice, "To move from a manual to a computer system means that your financial and other administrative records must be well organized, with systems that work well now."

Too often employees in the medical office find themselves unable to cope with the present system and leave, new employees then attempt to cope with an already eroding process. The decision to consider a computer should begin long before the need arises, through careful planning and evaluation of future needs and goals.

"Wanting" a computer means that the goals and future needs of the medical office have been evaluated. Office space has been examined and future moves considered. The possibility of additional physicians joining the practice, just as the growth in the number of patients in the practice will also have been reviewed.

A list should be made of the number of functions that are desired in a computer system in addition to a list of those that are definitely not wanted in the system. Flow charts can be made that show how a patient is carried through the office and what type of system could be implemented to make this process more efficient.

The medical office staff should also be aware of the interest in computerization and their comments sought when possible. The importance of a supportive staff cannot be understated and the physician's responsibility in providing motivation, defining expectations and setting goals is vital to the success of a new system.

According to Edward J. Beranek, computer consultant, "Without this type of support, the new system could easily fail. One medical office purchased a used computer system from that of a colleague, but failed to secure training for the office staff. The result being a system that has been sitting unused for a year, with both benefits and financial investments lost.

The most important benefit of a computer system in the medical office is its ability to provide timely information for management decisions. A computer system can promote better cash planning by keeping the physician continually appraised of the practice's cash position; it can monitor costs so that adjustments can be made quickly; it can provide rapid answers to patient's questions about their account; and it allows tighter control

over inventory by providing current information for assessment of future needs.

A computer system rarely reduces personnel, but it can reduce the number of additional personnel that will be needed as the practice grows. A related benefit is that disruption due to employee turnover is minimized since the best computer financial systems are well documented. The accuracy of a computer system can save money in lost accounts that occur from human error. The increased communication aspects of a computer system are also advantageous since direct lines can be established between office and hospitals to transmit patient data, with vendors for purchasing access and with national data banks for patient and medical information.

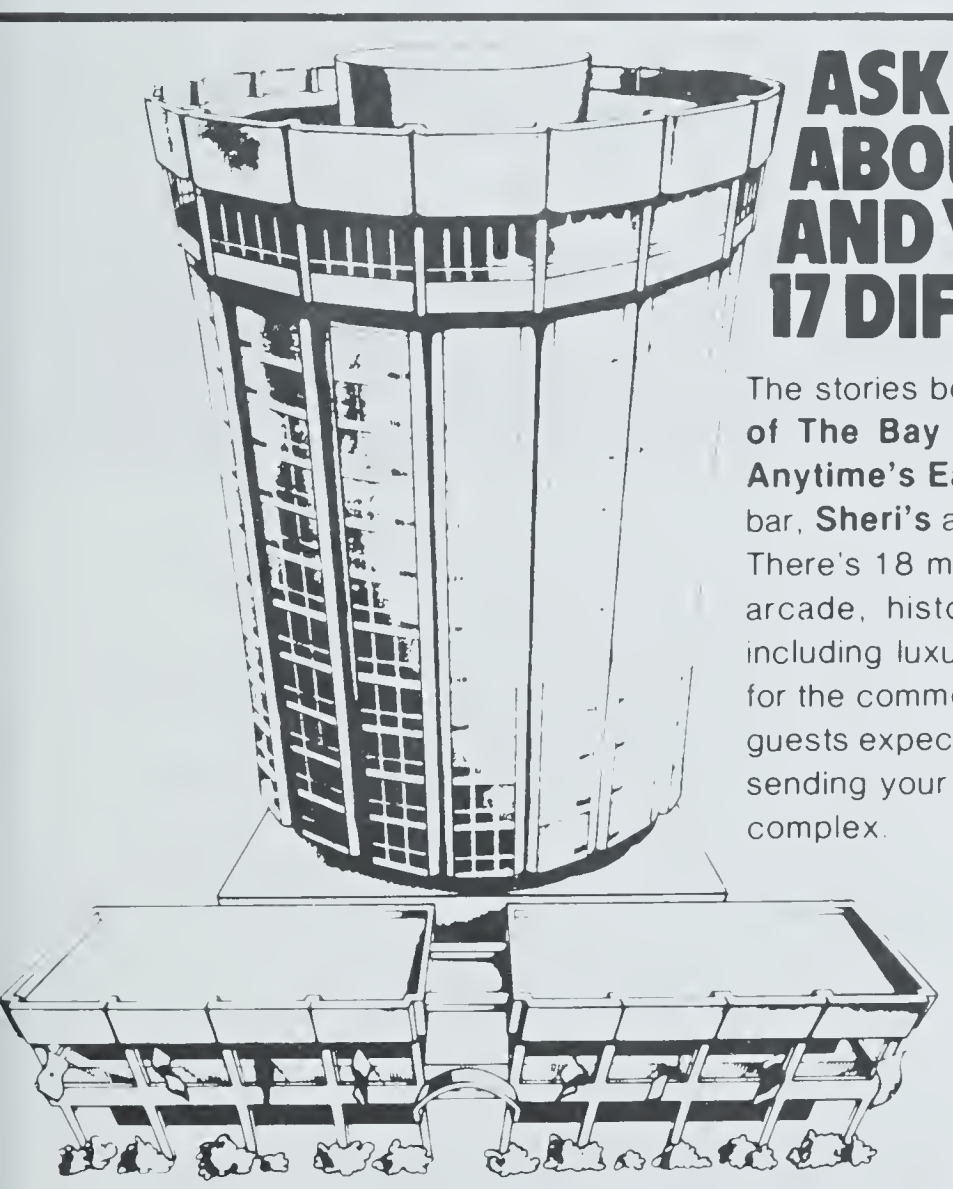
The word processing capability of a computer system enables the medical office to send out personalized individual letters to each patient regarding patient appointments or office policy changes. With the hardware and software present today, the medical office has no limit to the combinations of systems available.

Purchasing adequate hardware in this sophisticated day and age is relatively simple since most hardware is more alike than dissimilar. The only item not consistent is the price, which can vary from $10,000 to $80,000. The three items that must be closely evaluated are: 1. the ability to operate more than one terminal from a single computer; 2. the nature of the printer and 3. the computer's storage capacity (memory).

The type and amount of information to be entered into the system defines the number of required terminals, the volume of reports to be printed determines the number and speed of the printers, and the quantity of data to be processed determines necessary disk storage and CPU capacity. Computers advertised as "personal" computers may not be able to handle the needs of a medical office and will limit the user's ability. Many offices have invested in small "personal" computers advertised by the local hobby shops only to find them too slow and without adequate memory. Investigate whether the information storage capacity and number of terminals can be increased to serve future demands and if so what it will cost.

Screens should have a 24-line, 80-character display that is easy to read and easily accessable. Full screens are much more time saving than half screens since it is not necessary to continually hit the recall key to bring up the information required. The display on the screen should also be evaluated as several office staff have complained of difficulty in reading the green lettering on a black background.

Many offices prefer the white lettering with the black



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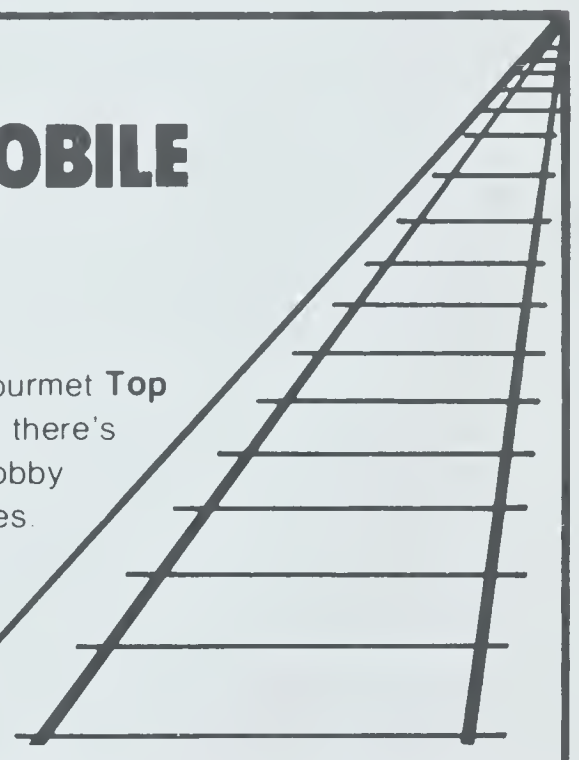

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background for this reason. One system demonstrated revealed a rather time consuming correcting mechanism that consisted of continual backspacing until you reached the error. This maneuver may have gone quickly during the demonstration but in an actual patient-care setting, this could have greatly delayed the physician's and patient's schedule.

Memory storage on the computer is measured in "bytes" or "megabytes" (millions of bytes) and are maintained as magnetic signals in three forms, reel of tape, disk pack and floppy disk. In order to visualize the units of memory in each of these forms, I will compare them to a 950 page novel. The comparisons are as follows: a reel of tape is equivalent to 15 novels, a disk pack is equivalent to 33 novels, and a floppy disk equivalent to 1 novel.

The reel of tape storage system is usually found on large computers, whereas the majority of microcomputers use the disk pack or floppy disk type storage. The cheapest item that can be purchased on a computer is the memory, therefore it is always wise to purchase as much as possible. Vendors should provide the customer with the appropriate amount of storage to cover current accounts and future projections. One source recommended that a prospective computer buyer should purchase a computer with the memory capability to increase the present accounts five times.

Printers are a part of the peripheral system of the computer and vary in cost from $400 to $3000. Printers enable the user to maintain a paper or "hard copy" of any information stored in the computer, or assist in processing statements to be sent out. Printers that produce typewriter quality print are preferrable as they can also be used for the computer's word processor capability.

The matrix printer which electronically sprays the letters onto the paper is one of the fastest and most expensive printers, but in this case the most expensive is not necessarily the best. Insurance forms that are printed by the matrix printer are rejected by many optical scanners used by several insurance companies. One office that spent the extra money on the matrix printer found it had to manually resubmit all insurance claims because the originals could not be processed with the type of print produced by the printer.

When a printer is purchased with a system, care should be taken to purchase a printer without a keyboard. The terminal should contain the keyboard and an additional keyboard on the printer is an unnecessary waste of money. The reliability of the hardware should be evaluated carefully as should the firm which will be installing and maintaining it.

One way is to check a year old issue of *Byte* or *Interface Age* in order to determine whether the company was in business and advertising at that time. If they were active a year ago then there is a good chance they will be worth investing in now. The installation and main-

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tenance costs should be considered and names of other customers obtained as references regarding reliability of service. Most reliabile computer firms will offer a trial demonstration period when the computer can be set up in the office and the available equipment assessed under normal circumstances. This should always be done before purchasing a computer system to assure that the system meets the required needs.

In evaluating the right system for the medical office, it should be remembered that the most advanced hardware will not meet the practice's needs without well designed software to instruct it. One computer consultant pointed out that, "The more emphasis a salesman puts on hardware, the more novice he actually is in selling a computer system."

Software determines the ease and convenience of the system's operation, how efficiently tasks are performed, what data is input, and what information is output. Selecting proper software is not an easy decision in today's complex market, but an intelligent choice can be made after careful evaluation.

Consideration should be given to the tasks the physician wants the software to perform, software quality and availability and the software consultant's record of supporting it (support includes operator training, making software improvements available and providing ongoing maintenance). Software should be developed by people who understand the complexities of medical accounting; writeoffs or adjustments, third party payments, duplicate payments and incorrect rejections.

The procedure and diagnosis file should allow for additions or deletions without calling in a programmer. It should have built in assistance prompts. By typing in a question mark or phrase, the user should be able to receive the proper response to enter, so that the infrequent user will not have to continually refer to a manual.

The potential buyer should insist on a test drive and try it out; enter a patient into the terminal, post charges and payments, change an address; think of a problem that occured in the office recently and duplicate the situation to see how the computer handles it.

Integration and standardization is another factor which plays a role in the ease of operation of software. Modules, such as accounts receivable and accounts payable, are combined to create a software system. In an integrated system, modules are tied together so information from one automatically flows into another. In this way errors and duplicate entries are reduced.

Standardization means that the screen displays all modules in the same form, that terminology, report formats and prompts are consistent and that the sequence of entering and posting information is uniform. Software should be written in standard programming language and the source code (the actual listing of the program statements) must be accessible by the end user or purchaser.

With the source code, the purchaser would be able to hire a programmer to support the software if the company or person selling the software should go out of business. The operator's manual should be understandable and provide step-by-step directions and assistance in the operation of the system. A well written manual can benefit the office staff in smoothing the transition period.

Finally, it is worthwhile to find out about system enhancements, program changes that increase information processing capabilities, meet changing industry needs or otherwise improve the software. Program corrections are often necessary because no system is entirely bug-free. A well designed system minimizes the number of bugs, while good support means any bugs that do occur will be dealt with promptly.

The most simple and straightforward system for the medical practice is the total package system. With these systems, the vendor supports the hardware, the servicing, the original programs, program modification and maintenance, training of the office personnel and assistance with all phases of the installation. There are companies that provide "canned" or prewritten software packages, however most of these programs have been developed quickly and rushed to market to meet the demands of the purchasers. Many have not been tested extensively and may have been designed for a particular practice and very few will function even minimally without extensive modification.

After the selection of hardware and software is complete, the next stage is the preparation necessary for the installation and successful integration of the computer into the medical office. This period requires a serious commitment from the office personnel since it can be an extremely difficult time for the entire office. Medical office personnel rarely look at the implementation of a computer system with great pleasure, even though it might mean increased efficiency and easier ways to complete their tasks. There are two reasons for this, one is simply the inconvenience of having to do something different, something that requires time and patience to master; the other is the fear of automation eliminating job positions. Both of these elements can be dealt with through effective orientation and communication between staff, physician and computer representative. If the staff has been involved in the process of selecting a computer, they will already be aware of the many functions that can be performed in a simplier fashion by the computer. Those occupying the administrative positions within the office will continue to perform their same tasks since the computer must have operators. If anything the implementation of a computer will allow the administrative staff more time to work on office collections and inventory control. If a computer did replace a position within the medical office, then that position was probably not as important as it appeared and most likely should have been eliminated prior to automation.

A transition team should be established in the office prior to installation and an operations manager designated to establish a tentative implementation schedule and assign tasks to be performed. The transition team must organize the conversion of data for entry into the computer, a function that may take several weeks or months to complete. Such forms as checks, invoices and statements must be designed and ordered, as should any additional storage elements such as additional floppy discs.

The new installation should run in parallel with the existing record keeping system for a time, usually two to three months, to provide back-up support for possible errors that could occur during the staff adjustment period. During this phase, care should be taken to avoid overworking the staff so that adequate time is provided for learning the new system.

Scheduling a light patient load will greatly enhance this purpose for the first week during installation. The computer representative should be of great assistance in this transition period and provide adequate support. The training of office personnel should be included in the purchase contract, however additional amounts may be charged for training additional personnel and this should be addressed at the time of the completion of the contract.

Despite our present level of technology, there are still relatively few computers in the medical office. Reasons for this range from the fear that computers may reflect a depersonalization of the physician's office to exaggerated horror stories from colleagues who have tried a computer and failed.

The concept that this technology would disrupt the basic foundation of the patient-physician relationship any more than any manual process employed in the medical office is completely unfounded. When a patient completes his or her office visit, various administrative functions must take place to assure that charges are recorded correctly and efficiently.

Whether those tasks are performed on a day sheet, a pegboard or typed into a computer terminal certainly does not effect the relationship of the office to the patients. The office personnel that carry out these functions are responsible for providing a warm and friendly communication link and if these extensions of the medical office are cold and insensitive the physician-patient relationship will deteriorate no matter what type of system is utilized.

There is additional disillusionment of physicians with this new field that is fostered by the lack of educational support for proper office management and decision-making. This feeling is not only felt by the physician community but by the administrative support staff as well. Several years ago the Medical Group Management Association (MGMA) reported that a bad computer decision was one of the most frequently cited reasons for replacing a medical group manager. For this reason, at a recent MGMA workshop, a recommendation opposing the installation of an in-house system for groups of less than ten physicians was accepted.

Yet, according to Dr. Ralph R. Grams, Chairman of the Division of Medical Systems at University of Florida:

"Contrary to the experts who point to the failures and problems, medical computing should and is going to advance. The financial and administrative bench marks reached in industry will eventually be achieved in medical practice, mainly because of the pressures for accountability, increased productivity and the potential for actual cash savings."

Dr. Grams feels that education is indeed the answer for the "hundreds of thousands of health care personnel who are apprehensive of, ignorant about, or totally disinterested in medical systems and computers."

The computer in the medical office is not simply a solution to a problem, it is a tool, similar to a hammer or nail used to build a structure. A computer is not a necessity and one may ask, "Why would anyone consider spending $10,000 to $80,000 for an item not required for survival?"

The reason is similar to that for the purchase of a new car, assurance of adequate up-to-date service before the old system breaks down. The selection of the total medical computing system can be as effective as the person selecting it is knowledgable. Proper study and thorough investigation can help assure an adequate system is installed. It can appropriately place the practicing physician in complete control of his practice.

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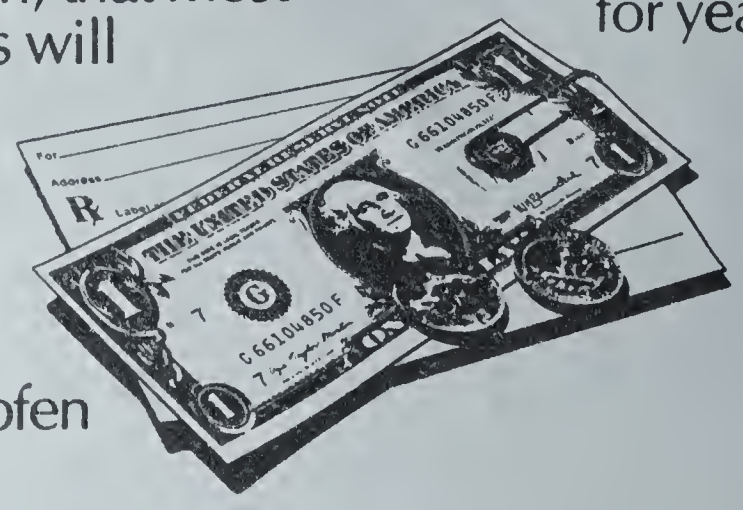

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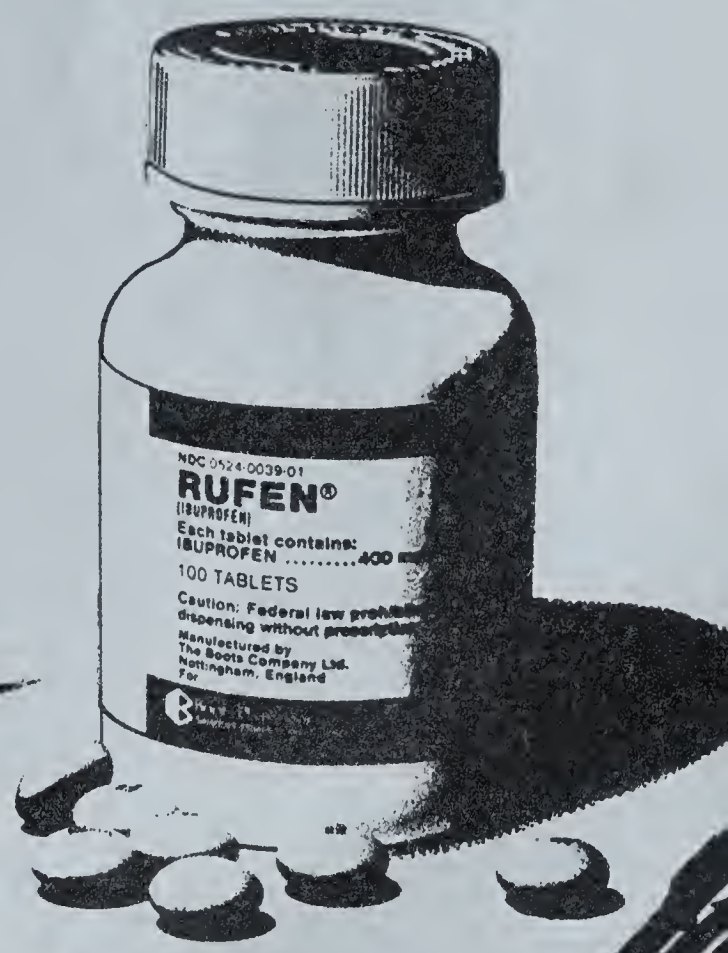

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WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

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Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

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Fine Needle Aspiration— A Six Year Experience at the University of South Alabama Medical Center

By Alfred B. Chance, Jr., B.S. (CT)*
Edmund A. Dowling, M.D.*
William A. Gardner, Jr., M.D.*

Aspiration biopsy is a diagnostic technique used to obtain a cell sample from organs which do not shed cells spontaneously. The specimen obtained is mostly cytologic and in that way differs from the core of tissue yielded by the cutting edges of other biopsy needles such as the Vim-Silverman. The small gauge of the needle (20-23) has significantly reduced the risk of serious complications compared with larger core needles[1,2]. Fine needle aspiration has been popular in Europe for many years and, more recently, has gained increasing acceptance in the United States. The long, flexible Chiba needle, designed at Chiba University, Japan, has expanded the utility of fine needle aspiration from superficially palpable lesions to lesions deeply seated in body cavities or organs. Such specialized needles, expertly placed by means of modern imaging techniques and interpreted with increasing cytopathologic expertise, have served to offset the major disadvantages of needle aspiration, which are the small volume of the specimen and the frequent absence of histologic detail[3,4,5,6,].

The purpose of this report is to describe our evaluation of the diagnostic accuracy of fine needle aspirations performed at the University of South Alabama Medical Center.

Fine needle aspiration cytology has been applied to many organs including liver, lungs, pancreas, lymph nodes, kidney, thyroid, prostate, and other sites within reach of a needle[7]. The primary use of the fine needle at the University of South Alabama Medical Center has been in the aspiration of liver, lungs, kidneys, and lymph nodes.

Materials and Methods:

This study utilizes 73 cases in which fine needle aspirations were performed. In the case population, there were 52 men and 21 women, ranging from 18 to 82 years of age. Forty-one cases were lung aspirations, nine liver, 18 renal cyst, and seven aspirations were from lymph nodes and body masses. All patients had been subjected to other diagnostic procedures such as repeated chest x-rays, tomography, sputum cytology, bronchoscopy, "metastatic workup", including nuclear scanning, ultrasonic scanning, and searches for primary tumors. Most of the needle aspirations were deep body aspirations with only a few from superficial, palpable lesions.

The diagnoses made on the aspirates were confirmed or revised by histology, bacteriology, surgery, or the eventual clinical course of the patient. In the majority of patients with cytologic diagnosis of benign disease, surgery was not performed and histologic verification was not obtainable. The cytologic diagnosis in these cases was considered correct based upon the patients clinical course. Follow-up was restricted to medical records located at the hospital.

The primary needle used at the University of South Alabama Medical Center was the Chiba needle, a thin walled, flexible 23 gauge needle which measures 15 cm in length, 0.7 mm in outer diameter, 0.5 mm in inner diameter, and has a bevel angle of 30°. A large bore needle may be used in transthoracic or transperitoneal fine needle aspirations to serve as a cannula, allowing

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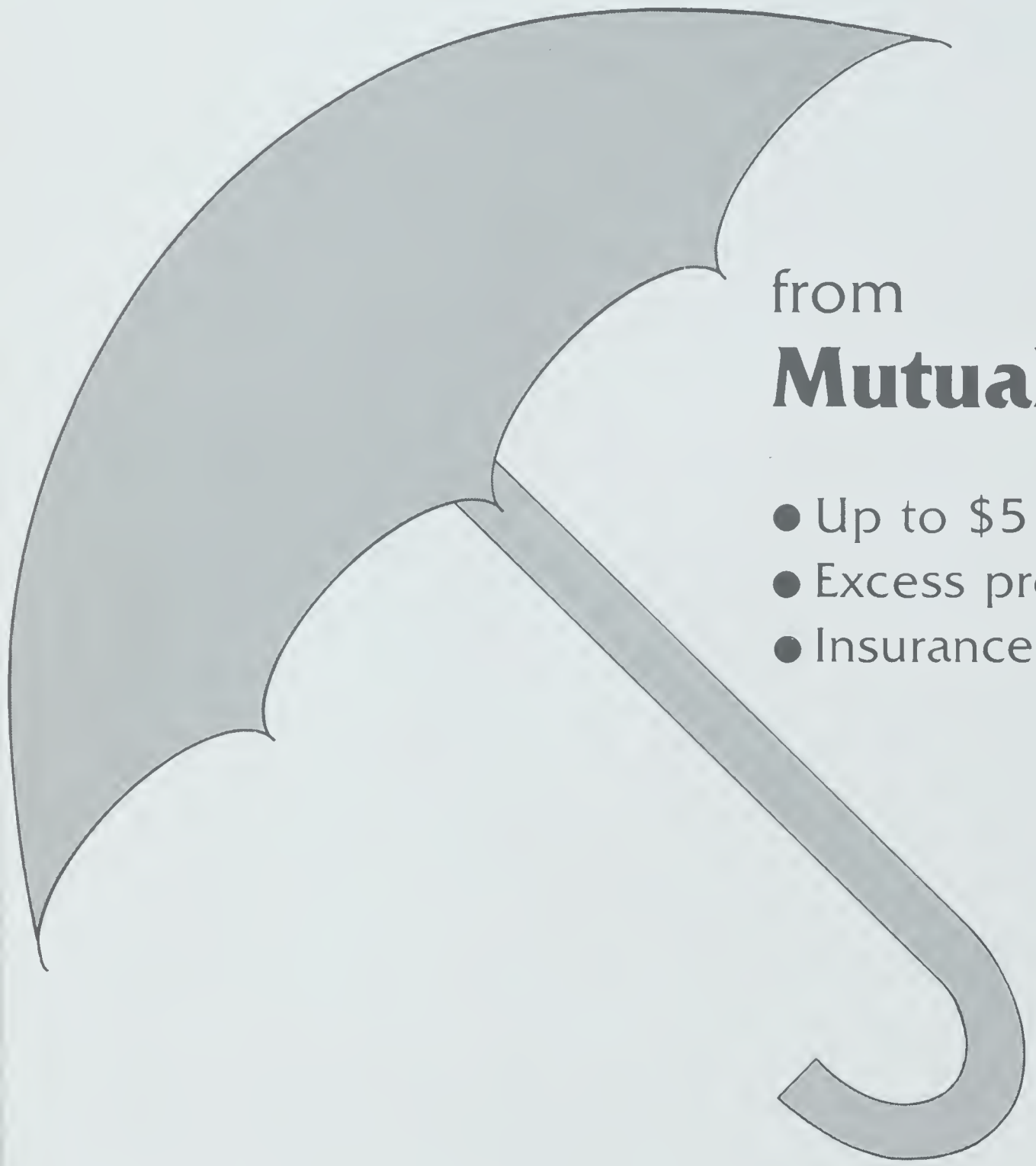

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the flexible Chiba needle to bypass the thick tissue and muscle of the cavity walls. Occasionally a 20-22 gauge spinal type needle was used.

For the majority of cases (41/73) the following procedure was utilized: after localization of pulmonary lesions by fluoroscopy and radiography of the chest, the patient was examined in the position which allowed the most perpendicular and shortest approach to the lesion. Under fluoroscopic control, a point was marked on the skin directly overlying the lesion. After infiltration of the skin and chest wall with local anesthetic, a scalpel was used to make a stab wound and the needle advanced slowly toward the lesion. Fluoroscopy aided straight passage of the needle. Appropriate needle depth was determined by the previous chest x-ray, tomography, or by the sense of difference in consistency. After removal of the internal stylet, a 20 ml plastic syringe was attached to the needle. As suction was applied to the syringe, the needle was moved back and forth over a distance of 0.5-1.0 cm, suction released, and the needle removed. The material obtained was immediately smeared on glass slides and fixed in 95% ethyl alcohol. In a few cases cell blocks for paraffin section was obtained. After biopsy and expiration, frontal radiographs of the chest were routinely taken to evaluate the possibility of pneumothorax. All specimens were stained with the Papanicolaou stain.

Fine needle aspirations of sites such as abdominal and retroperitoneal organs, cervical, axillary, abdominal and retroperitoneal masses or nodes have utilized other radiographic procedures such as scanning techniques and ultrasound to localize lesions[2,5,8].

Results:

In our 73 cases, 98.6% of the cytologic material was suitable for diagnosis. A positive diagnosis was made in 81.3% of cases. There were no false positive diagnoses among 41 benign lesions.

Lung: There were 25 confirmed carcinomas of the lung. A positive diagnosis was made in 76% of the cases. Three cases were called negative and an additional three were called suspicious. This results in a false negative rate of 12%.

Of the 25 confirmed carcinomas, 10 were squamous cell type, nine adenocarcinomas three undifferentiated small cell carcinomas, two poorly differentiated carcinomas, and one alveolar cell carcinoma.

Of the 16 benign lesions, further clinical studies showed that they represent four cases of tuberculosis, three granulomas, one cavitary lesion of unknown etiology, one case of systemic lupus erythematosus, and seven inflammatory conditions of unknown etiology.

Liver: There were three confirmed carcinomas of the liver, two hepatomas and one metastasis, on each of which positive cytologic diagnosis was made. There were no false positive diagnoses among six benign lesions representative of hepatitis, liver abscess, hematoma and necrosis.

Nodes: There were four confirmed metastatic carcinomas within nodes from various body sites. A positive diagnosis was made in 100% of the cases. Of the four carcinomas, two were oat cell carcinoma and two were of squamous cell type. The only benign case was correctly diagnosed.

Renal Cyst: There were no confirmed carcinomas of the kidney. A negative diagnosis was made in 100% of the 18 cases. The negative diagnoses were confirmed by further clinical study.

Discussion

Fine needle aspiration has been used increasingly at the University of South Alabama Medical Center since 1975.

The increased acceptance of the technique has been largely due to four factors: 1) improved radiologic technique, especially fluoroscopy, for direct biopsy control, 2) advances in and increasing acceptance of cytologic diagnosis, 3) development of the Chiba needle, and 4) improved technique with few biopsy related complications[2,6,8,9,10]. Thus, fine neddle aspiration has proved to be a safe, fast, and highly accurate procedure which allows cytologic diagnosis of malignancy without exploratory surgery, prolonged hospitalization or delay of treatment.

Fine needle aspiration may also be used: 1) in the staging of neoplasms, 2) for the bacteriological and cytological diagnosis of infectious disease such as tuberculosis, and 3) in the diagnosis of renal cysts[2,5,11].

A positive diagnosis was made in 81.3% of the 32 confirmed carcinomas. If the three lung aspirations which were called "suspicious for malignancy" are counted with the positive diagnoses, the diagnostic accuracy is 90.6%. This is comparable with that of other studies which range from 81.6 to 96.5% overall diagnostic accuracy[4,5,6,8,9,12]. Diagnostic accuracies for the individual body sites are also comparable with those of other studies.

It has been demonstrated that percutaneous needle aspiration of the smaller, more peripheral pulmonary lesion has been more successful in the cytologic diagnosis of malignancy than have traditional bronchial cytologic procedures (sputum, bronchial wash, bronchial brush[13]). Although the specific location of lesions was not indicated in our cases, the results will suggest the superior diagnostic accuracy of fine needle aspiration over traditional cytology. Therefore, it is considered that fine needle aspiration of the lung is a more reliable procedure than traditional cytology in the detection of malignancy, especially in smaller more peripheral lesions. The rarity of a false positive diagnosis indicates that a positive result is a reliable and definitive diagnosis which may lead directly to treatment[12].

The use of fine needles in the aspiration procedure has significantly reduced the number of complications that are associated with large bore biopsy needles such as Menghini and Vim-Silverman[1,2,4,14]. The most com-

mon complication in lung aspiration is pneumothorax. The reported percentages of cases which suffer from post aspiration pneumothorax range from 0% to 57%[6,10,12]. In this study there was a pneumothorax rate of 43.9% with 9.8% requiring chest tube drainage. Hemoptysis occurred in one case. Although the rate is within acceptable limits, there is some indication that it may be improved by use of a one pass method which utilizes a quick stain process for evaluation of adequacy of sample 5 to 10 minutes after collection. If the first pass gives good results, then there is no need for further passes through the lesion[15]. Three passes was the minimum number used in our case population.

Needle tract dissemination of malignant cells has been reported in the literature[14], but the rarity of this occurrence has not influenced the procedural indications for fine needle aspiration. Seeding along the needle tract is far less than that reported with cutting biopsy needles.

Tuberculosis and other granulomas made up 45% of our benign cases. Of the four cases which were clinically diagnosed as tuberculosis, none was diagnosed as such cytologically, although the cytology was compatible with tuberculosis. In smears with finely granular necrotic material, increased numbers of lymphocytes, multinucleated giant cells, epithelioid cells or small calcium fragments, an infectious granuloma should be suggested as a guide to definite microbiologic evaluation of the patient[7,11].

Summary

The overall diagnostic accuracy of fine needle aspiration at the University of South Alabama Medical Center was 90.6%. It is clear that fine needle aspiration has become a valuable procedure in the diagnosis of malignancy and will continue to gain greater accuracy as techniques of specimen collection and evaluation improve.

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CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitra activity than ather drugs in the ampicillin class and its use shauld be canfined ta these indicatians: Treatment af the follawing infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Graup A beta-hemalytic streptocacci
Bronchitis and pneumania caused by *S. pneumaniae* (farmerly *D. pneumaniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumaniae*) and *H. influenzae*
Acute exacerbatian of chronic branchitis caused by *H. influenzae**
*Thaugh clinical impravement has been shawn, bacterialagic cures cannat be expected in all patients with chranic respiratary disease due ta *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infectians caused by Graup A beta-hemalytic streptocacci and staphylocacci, nanpenicillinase praducers.
URINARY TRACT INFECTIONS caused by *E. cali* and *P. mirabilis*. (This drug shauld nat be used in any *E. cali* and *P. mirabilis* infections ather than urinary tract.)
NOTE: Perfarm cultures and susceptibility tests initiolly and during treatment ta manitar effectiveness af therapy and susceptibility af bacteria. Therapy may be instituted priar ta results af sensitivity testing.
Contraindications Cantraindicated in individuals with histary af an allergic reactian ta penicillins.
Warnings Cyclacillin should only be prescribed for the indications listed herein.
Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.
Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.
Precautions Pralanged use af antibiotics may promote avergrawth af nansusceptible arganisms. If superinfectian accurs, take appraapriate measures.
PREGNANCY: Pregnancy Categary B. Reproduction studies perfarmed in mice and rats at dases up ta 10 times the human dase revealed na evidence af impaired fertility ar harm ta the fetus due ta cyclacillin. There are, hawever, na adequate and wellcontralled studies in pregnant wamen. Because animal repraduction studies are nat always predictive af human respanse, use this drug during pregnancy anly if clearly needed.
NURSING MOTHERS: It is nat knawn whether this drug is excreted in human milk. Because many drugs are, exercise cautian when cyclacillin is given ta a nursing waman.
Adverse Reactions Oral cyclacillin is generally well talerated. As with other penicillins, untaward sensitivity reactians are likely, particularly in thase wha previausly demanstrated penicillin hypersensitivity or with histary af allergy, asthma, hay fever, ar urticaria. Adverse reactians reparted with cyclacillin: diarrhea (in appraximately 1 aut af 20 patients treated), nausea and vamiting (in appraximately 1 in 50), and skin rash (in appraximately 1 in 60). Isalated instances af headache, dizziness, abdaminal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactians which may accur and are reparted with ather penicillins are anemia, thrombocytapenia, thrambocytopenic purpura, leukapenia, neutrapenia and easinaphilia. These reactians are usually reversible an discantinuation of therapy.
As with ather semisynthetic penicillins, SGOT elevatians have been reparted.
As with antibiatic therapy generally, cantinue treatment at least 48 ta 72 haurs after patient becames asymptamatic ar until bacterial eradicatian is evidenced. In Graup A beta-hemalytic streptacaccol infectians, at least 10 days' treatment is recammended ta guard against risk af rheumatic fever ar glamerulanephritis. In chranic urinory tract infectian, frequent bacterialagic and clinical appraisal is necessary during therapy and passibly far several manths after. Persistent infectian may require treatment far several weeks.
Cyclacillin is nat indicated in children under 2 manths af age.
Patients with Renal Failure Cyclacillin may be safely administered ta patients with reduced renal function. Due ta pralonged serum half-life, patients with variaus degrees af renal impairment may require change in dasage level (see DOSAGE AND ADMINISTRATION in package insert).
Dosage (Give in equally spaced dases)

INFECTION	ADULTS	CHILDREN*
Respiratary Tract		
Tansillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumania		
Mild ar Maderate Infectians	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chranic Infectians	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg ta 500 mg q.i.d.†	50 ta 100 mg/kg/day†
Skin & Skin Structures	250 mg ta 500 mg q.i.d.†	50 ta 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dasage shauld nat result in a dase higher than that far adults.
†depending an severity

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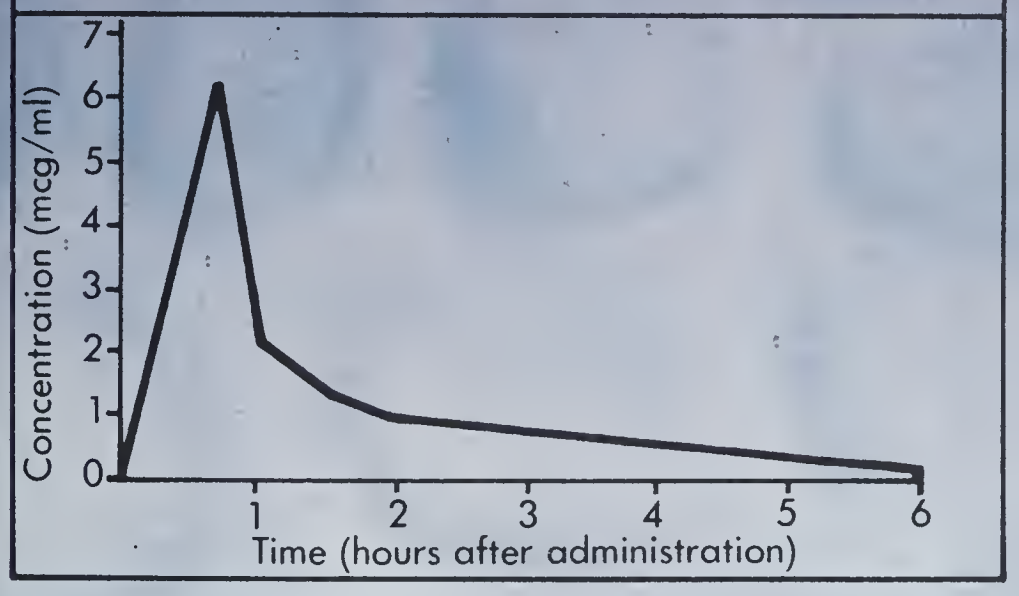

- Rapid, virtually complete absorption from GI tract
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- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T^{a} ½ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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See important information on facing page.

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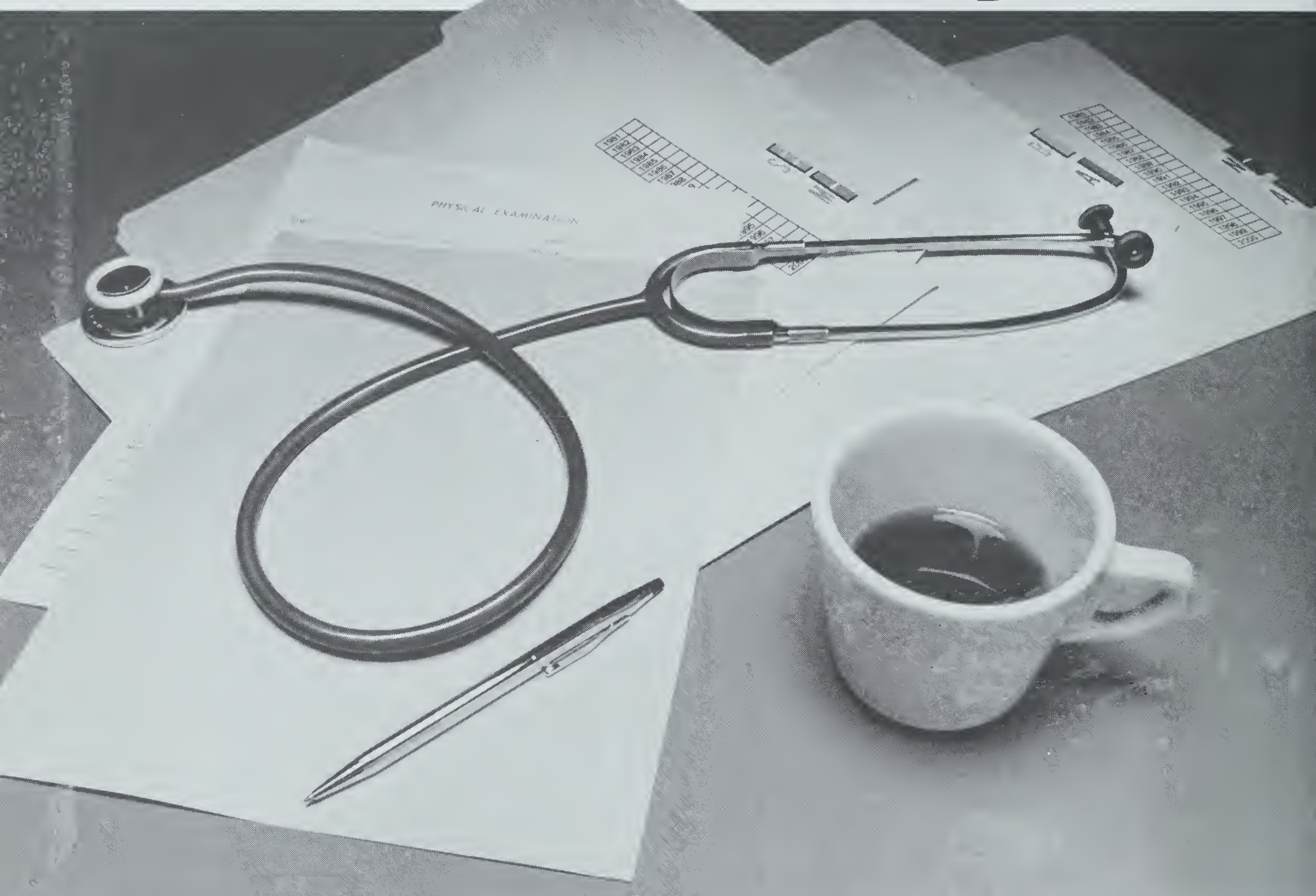

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Gastrinoma—Current Observations and Management Options

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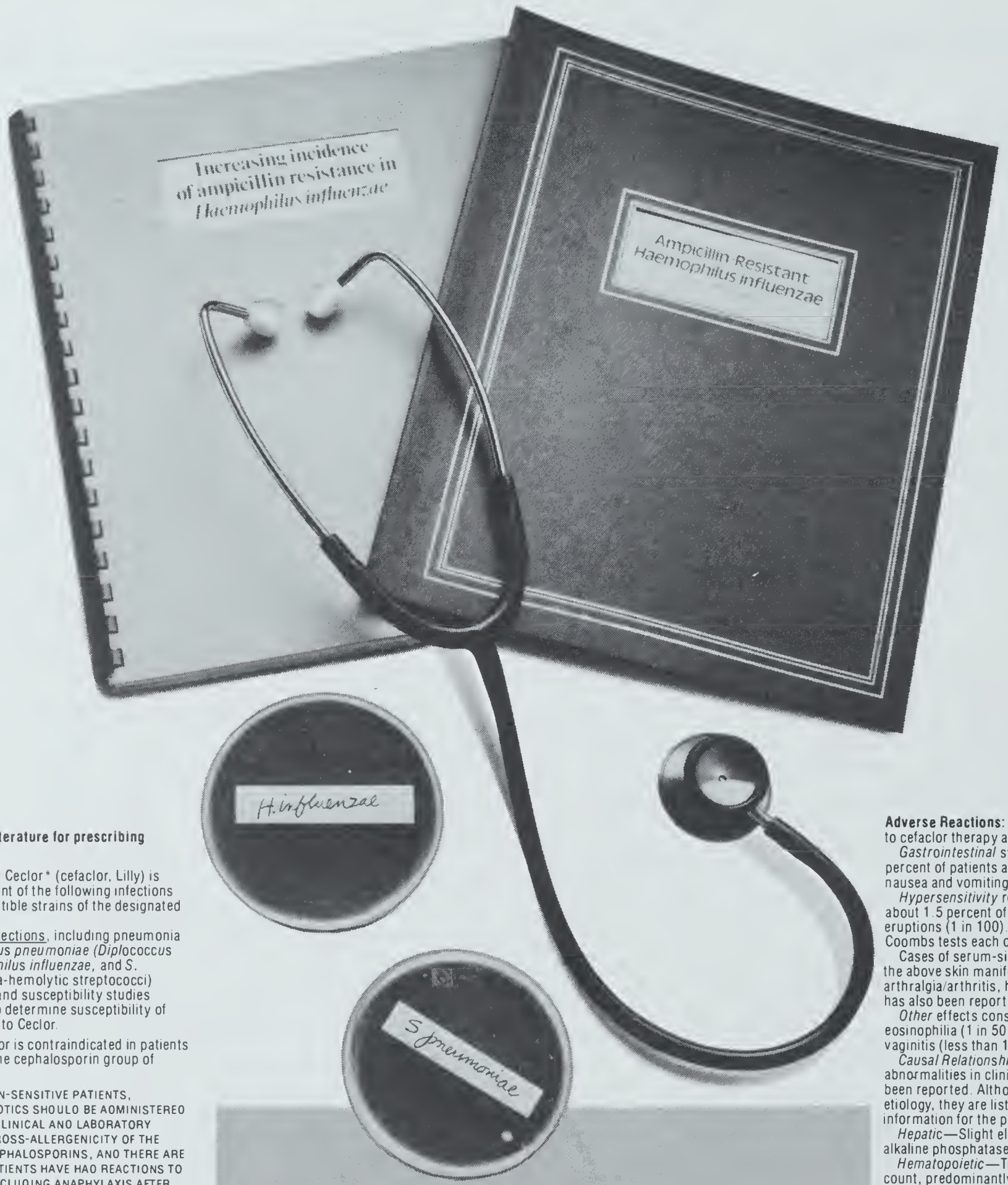
Now that the radioimmunoassay for gastrin is readily available, the diagnosis of gastrinoma or the Zollinger-Ellison syndrome is relatively commonplace and is frequently made before the fulminate symptoms of the disease occur. While the availability and use of the serum gastrin assay have altered the timing of diagnosis, the recent development and use of gastric acid secretion inhibitors have changed the management of the ulcerogenic syndrome. This review utilizes a survey of recent observations about gastrin and gastrinoma and the differences in the "classical" and more recent reports of the clinical setting of this disorder to formulate an approach to the disease. The clinical experience from this institution has been reported[1].

Before discussing the other aspects of a gastrinoma, some of the known facts about gastrin should be mentioned to elucidate the physiology of this disease. Gastrin is one of about forty gastro-intestinal hormones. A glycoprotein, it is secreted by the gastrin cell (G-cell) which is part of the neuroendocrine-APUD-system[2]. The cells of the APUD system are embryologically located in the neural crest and possibly the foregut and are totipotential; thus they can be found in tissue from a variety of sources such as pituitary, parathyroid glands, stomach and pancreas. The G-cells (as with other cells of the APUD system) when derepressed are frequently associated with multiplicity of tumors, hyperplasia and associated endocrinopathy[3]. There are six forms of gastrin with G_{34} and G_{17} being the more commonly known big and little gastrin; there are also mini, bigbig and component I gastrins, all of which have sulfated and non-sulfated forms[4]. Normally gastrin stimulates secretion from the antrum of the stomach, to a lesser degree the duodenum and is found in the fetal pancreas[3]. The hormone stimulates gastric acid secretions and, to a lesser degree, pancreatic enzyme secretion and stimulates growth of acid secreting mucosa. Since multiple forms of the hormone and multiple sites of secretion have been identified, many attempts have been made to show a specificity of various sites of secretion to one of the forms of the hormone. For example, it has been shown that the antrum secretes approximately 90-95% little gastrin(G_{17}) while the duodenum secretes about 50% big gastrin (G_{34}); in a normal subject, post prandial gastrin is 60-70% G_{34}. However, these measurements are certainly influenced by the fact that the renal clearance of G_{17} takes about six minutes whereas the G_{34} clearance time is about forty minutes[4]. Thus whether the recorded measurements reflect an actual predominance of secretion of a certain form of the hormone or the differences in clearance rates from the serum is as yet unclear.

Gastrin secretion is stimulated in the normal state most markedly by feeding digested protein and amino acids and to a lesser degree by fat or carbohydrate meals but not distention nor alkalinization alone. Normally feeding a mixed meal causes an increase in gastrin secretion of approximately 20-30%. The most marked response of the serum gastrin concentration is seen as a result of the change in the hydrogen iron content in the stomach. As the ph decreases so does the serum gastrin; at a ph less than 3.0, gastrin secretion is diminished and at a ph of less than or equal to 1.5 gastrin secretion is essentially stopped[4]. The normal serum gastrin ranges from 50-70 pg/ml; individual laboratories have varying maximal levels but currently the normal fasting gastrin is up to 300 pg/ml.

As has been reported on frequent occasions, there are multiple causes of an elevated serum gastrin. A knowledge of these is even more important as the diagnosis of the Zollinger-Ellison syndrome is more dependent on the serum gastrin levels and is being detected at an earlier stage—with a lower serum gastrin. Atrophic gastritis (chronic gastritis, gastric atrophy, achlorhydria) with or without vitamin B12 deficiency is the most common cause of an elevated serum gastrin[4]. There are an increased number of gastrin cells in the antrum and the normal acid-gastrin feedback control is interrupted because of the achlorhydria. Achlorhydria with B12 deficiency has the highest elevation of serum gastrin in this group; some pernicious anemia patients have a serum gastrin of 10,000 but the mean is 1,000 pg/ml. The presence of gastric ulcer or cancer would not alter the serum gastrin findings but feeding these patients will increase the serum gastrin. Hypergastrinemia with gastric outlet obstruction is probably due to retained food

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [1030BOR]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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since an elevated serum gastrin nor an elevated acid secretion are found with only distention. After gastric resection with a gastrojejunostomy, which again interrupts the normal acid-gastrin feedback control, a retained antrum will cause hypergastrinemia but this is readily delineated from the gastrinoma because secretion infusion (see below) decreases the gastrin in these patients. Another confusing post operative problem is post vagotomy hypergastrinemia. In this setting the decreased gastric acid causes an increased G-cell population and an associated elevated basal and post prandial gastrin level; however, the gastrin is not increased with secretin infusion. G-cell hyperplasia is a condition often mentioned but very few cases have been documented. It is important because the patient not only has an elevated serum gastrin and an acid hypersecretion but the hypergastrinemia resolves with an antrectomy. Fortunately, these patients are clearly delineated from the Zollinger-Ellison syndrome by an exaggerated response of the serum gastrin to feeding. Hyperparathyroidism has an associated elevated serum gastrin due to the elevation of serum calcium. However, there is no increase in acid secretion; if an increased acid secretion accompanies the elevated serum gastrin and hypercalcemia, the most likely diagnosis is MEA 1 not hyperparathyroidism. It is important to recall that multiple endocrine adenopathy I is associated with hyperparathyroidism about 87% of the time and about 40-60% have the Zollinger-Ellison syndrome[5]. Chronic renal failure is another case of hypergastrinemia and is becoming more commonly seen. One fourth of these patients have an elevated serum gastrin but they have a decreased gastric acid secretion. Elevations of serum gastrin have been reported with massive small bowel resection, pheochromocytoma and a few other miscellaneous causes[4,5].

The Zollinger-Ellison syndrome was initially described as a fulminating ulcer diathesis, excessive secretion of gastric acid and non-beta cell islet pancreatic tumors. These findings were soon associated with an elevated serum gastrin (incidentally the component is mainly G_{34}). Gastrinomas are composed of G-cells and, as mentioned earlier, have a potential for various sites, hyperplasis and associated endocrinopathy. However, the tumor is usually in the head or tail of the pancreas with a reported 10% in the duodenum and 10-15% each in the distal duodenum and jejunum[5]. Fifty to sixty percent are malignant and most patients are males between 20 and 50 years old. Classically, 90-95% of the symptoms of these patients were due to ulcers again described as possibly multiple and unusually located, but in fact 75% are single and in the duodenum[5]. In addition to ulcer pain, GI bleeding has been present in as many as 40% of the patients and the gastric hypersecretion has lead to significant problems with diarrhea in about one third of reported patients[5,6]. However, as reported recently, the clinical findings and the factors essential for diagnosis in patients with gastrinoma or the Zollinger-Ellison syndrome have changed over the past twenty years[8]. Deveney, Deveney, and Way found that in their patients diagnosed before 1970, 56% had virulent ulcer disease; gastric analysis and the demonstration of tumor at operation were both important diagnostic parameters; and 47% had an associated MEA. This almost parallels the findings of Fox and associates who reported in 1974 a 65% incidence of intractable ulcer symptoms with 12% having obstruction, anemia or diarrhea[9]. In that series, 35% of the patients had emergency operation and the initial symptom was ulcer pain in 68% of the group. However, in the patients managed since 1970 by Dr. Way and his associates, the most important factor in diagnosis was the serum gastrin. And in this recent group only 24% of the patients had virulent ulcer disease and 13% had an associated MEA. One of the more striking findings is that before 1971 only 16% of the patients were diagnosed as having the Zollinger-Ellison syndrome before having an operation for ulcer disease, whereas in the latter group, 61% of the patients diagnosed as having a gastrinoma had not had an attempt to correct their ulcer disease by operation[8]. As for an associated MEA-1 syndrome, a recent report indicates that individuals inheriting this trait will ultimately develop disease in all three endocrine systems (pancreas, parathyroid, pituitary) if long term follow up is complete[9]. Thus the clinical setting and means of diagnosing this disorder have changed in recent years.

With the earlier diagnosis, the milder symptoms and lower serum gastrin levels clear delineation between gastrinoma patients and those with hypergastrinemia from other causes is more uncertain. Currently, a fasting serum gastrin greater than 500 pg/ml is considered diagnostic of the Zollinger-Ellison syndrome if coupled with the appropriate clinical setting. However, as noted by Way and associates[8] some of the basal gastrin values from normal and gastrinoma patients overlap. As reported in their paper, this occurred in 41 of their patients with gastrin levels between 75 and 300 pg/ml; 49% of the patients with proven gastrinoma had basal gastrin levels below 500 pg/ml. Gastrinoma and non-gastrinoma patients have an overlap on values from gastric acid secretion studies. The Zollinger-Ellison syndrome is present in patients with gastric acid secretion greater than 100 ml per hour—or greater than 15 meg. of acid secretion per hour; basal acid output-maximal acid output ratios are usually greater than 60% in gastrinoma patients with most duodenal ulcer patients and normals having values less than 60%[5,11].

To aid in differentiation between gastrinoma and non-gastrinoma hypergastrinemia provocative tests have been developed. As noted recently, as many as 50% of patients having gastrinoma are diagnosed with provocative testing[12]. Although several of these tests have been developed, the most useful seem to be calcium, secretin and standard meal feeding. The responses and problems with each have been well docu-

mented[5,8]. The gastrin response to an intravenous infusion of calcium gluconate is most prominent between the second and third hour and a positive response is considered a greater than 50% increase in the serum gastrin or a greater than 500 pg overall elevation. More than 80% of the Zollinger-Ellison patients have a positive response with no or minimal response noted in duodenal ulcer or normal patients. However, 50% of the values from patients with pernecious anemia are within this positive range. Secretin infusion is safter, more rapid and has less false positive values. A secretin infusion is considered positive if the gastrin response is an increase greater than 400 pg. More than 90% of the gastrinoma or Zollinger-Ellison syndrome patients have a positive response and there is a 10% false negative response with almost no false positive values. No increase in the gastrin response with secretin infusion has been found with G-cell hyperplasia, pernecious anemia or retained antrum[5]. Feeding a standard meal as a provocative test causes an increase in the serum gastrin in normal and duodenal ulcer patients but not most of the gastrinoma subjects; the values from patients with gastrinoma show a minimal gastrin elevation usually to less than 50% above the basal value. Thus the gastrin profile in a patient with gastrinoma or the Zollinger-Ellison syndrome consists usually of a fasting gastrin greater than 300 pg/ml, a marked increase in the hypergastrinemia with calcium but more definitively with secretin provocative testing and no or a minimal increase with a standard meal feeding.

The Zollinger-Ellison syndrome once established, is best treated by total gastrectomy[6,8,10,11]. There are several considerations important especially to the surgeon performing the operation. Current data indicate that no tumor will be found in 30-60% of the patients[5,8]. In general, the disease has not been eradicated by isolated excisional therapy because of the multiple fossi of the disease; Zollinger reports having had one patient cured for at least nine years by excision of a solitary tumor[11] The procedure should include exploration of the duodenum and pancreas and the margins of the esophagus should be studied by frozen section to insure that no acid secreting cells remain[7,10]. Most authors recommend re-establishment of continuity of the GI tract with an esophagojejunostomy and a Roux-en-Y jejunojejunostomy[7,8,11]. It is not necessary to construct the end to side jejunojejunostomy to form a pouch[13] and patients with total gastrectomies done for gastrinoma have not had severe nor significant nutritional problems[14]. Survival figures for total gastrectomy have changed somewhat mainly when comparing the post operative mortality of about 11% reported in 1974[10] with the current mortality rates of 3%[8]. However, the long term survival figures have not changed significantly. As reported by Fox and associates patients with Zollinger-Ellison syndrome with liver metastasis having a one year survival rate of about 75%, five year 55% and ten year 42%[10]. This does not differ significantly from more recent figures. And of course the earlier reports confirm the much higher survival with total as compared with subtotal gastrectomy[7,10].

As mentioned earlier the introduction into clinical usage of the gastric acid secretion inhibitors has altered the clinical approach and may alter the treatment in the future. Cimetidine, is one of the gastric acid secretion inhibitors; of course the secretion of gastrin is unchanged by administering this drug. The drug offers an alternative treatment in the management of gastrinoma; the long term results with usage of the drug are unknown. McCarthy has reviewed the reported results in the United States; in the collected series of 61 patients treated with Cimetidine 48 had been on the drug but only one half of them for more than one year[15]. Most of the patients were taking 300 mg. of Cimetidine every six hours but some did require up to 600 mg. every six hours to control the pain and/or abolish diarrhea. Of those not on the drug at the time of his review significant problems had developed in five, another five died for reasons unrelated to the therapy and three, though well controlled, were apparently treated by operation. Another experience showed that of twelve patients treated with Cimetidine at the time of the report, seven were well and five had undergone operation—one for resection of an adenoma[8]. The long term results and usage of this drug have not been established but it is clear that Cimetidine is an important method of controlling the fulminant symptoms of the Zollinger-Ellison syndrome and avoiding emergency total gastrectomy especially in a hypovolemic actively bleeding patient. Gastric acid secretion inhibitors also give the surgeon the alternative of resecting an apparently single focus of tumor at celiotomy and then following the patient knowing that if symptoms recur, these drugs can be used to stabilize the patient for a total gastrectomy[16].

In summary, further research may identify specific sites of secretion of specific forms of gastrin. Such findings would allow development of more effective (and specific) gastric acid secretion inhibitors and/or antihormonal agents. Currently, a serum gastrin level should be obtained before an elective operation for peptic ulcer disease and for those patients with hypergastrinemia or peptic ulcer disease with a suspicious clinical or family history and findings, provocative testing is essential for diagnosis. Gastric acid secretion inhibitors certainly provide an excellent method of treating the patient with acute fulminate ulcer symptoms, including bleeding, while resuscitation in preparation for a total gastrectomy or for a trial of medical therapy is done. These agents also provide an alternate method of treatment when an apparently solitary resectable tumor is found at operation; the efficacy and feasibility of using them for long term therapy for gastrinoma has not been established. Finally, when a resection of stomach is needed a total gastrectomy is the procedure of choice.

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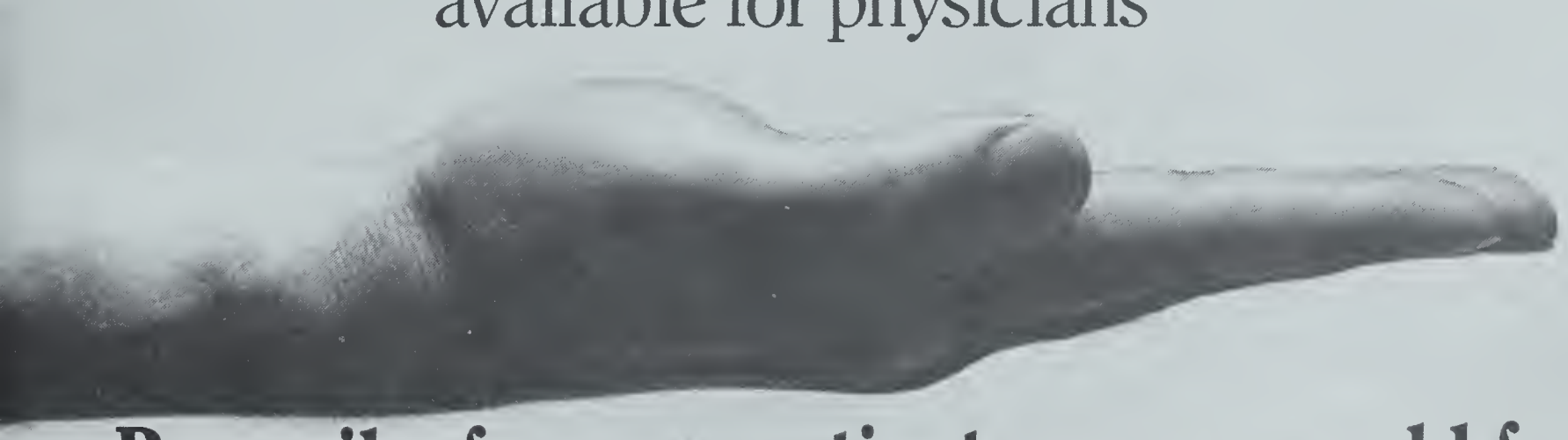

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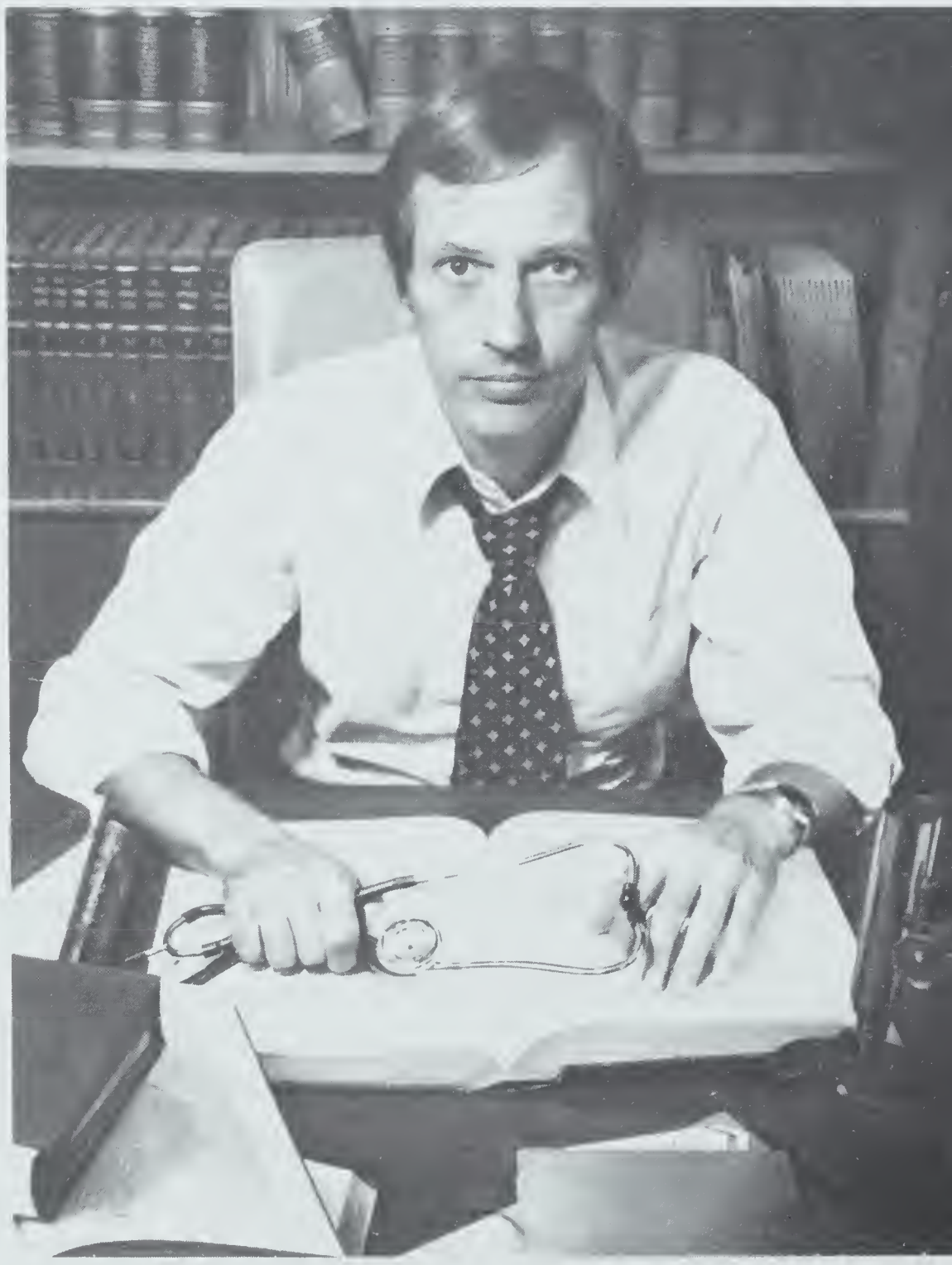

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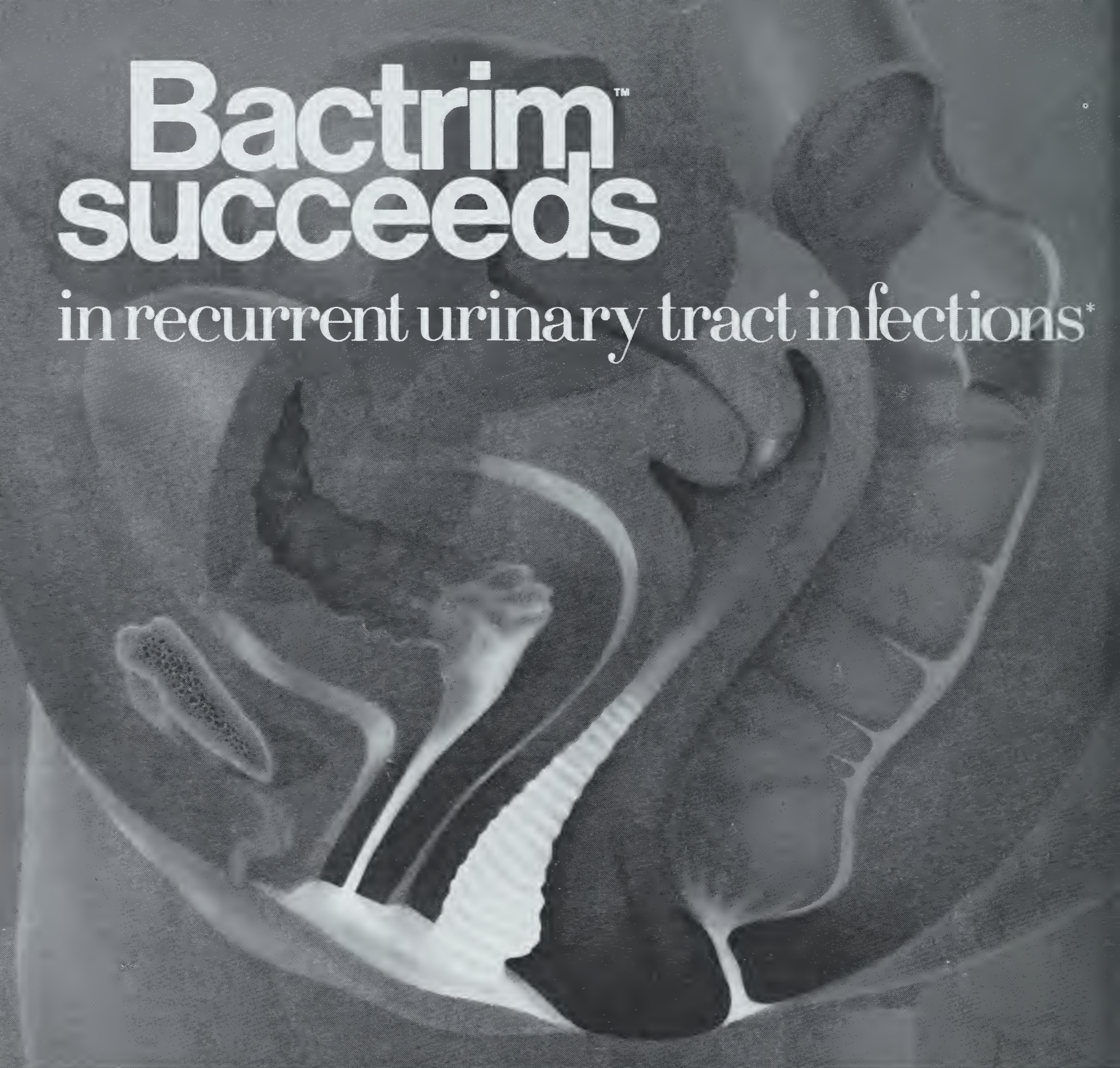

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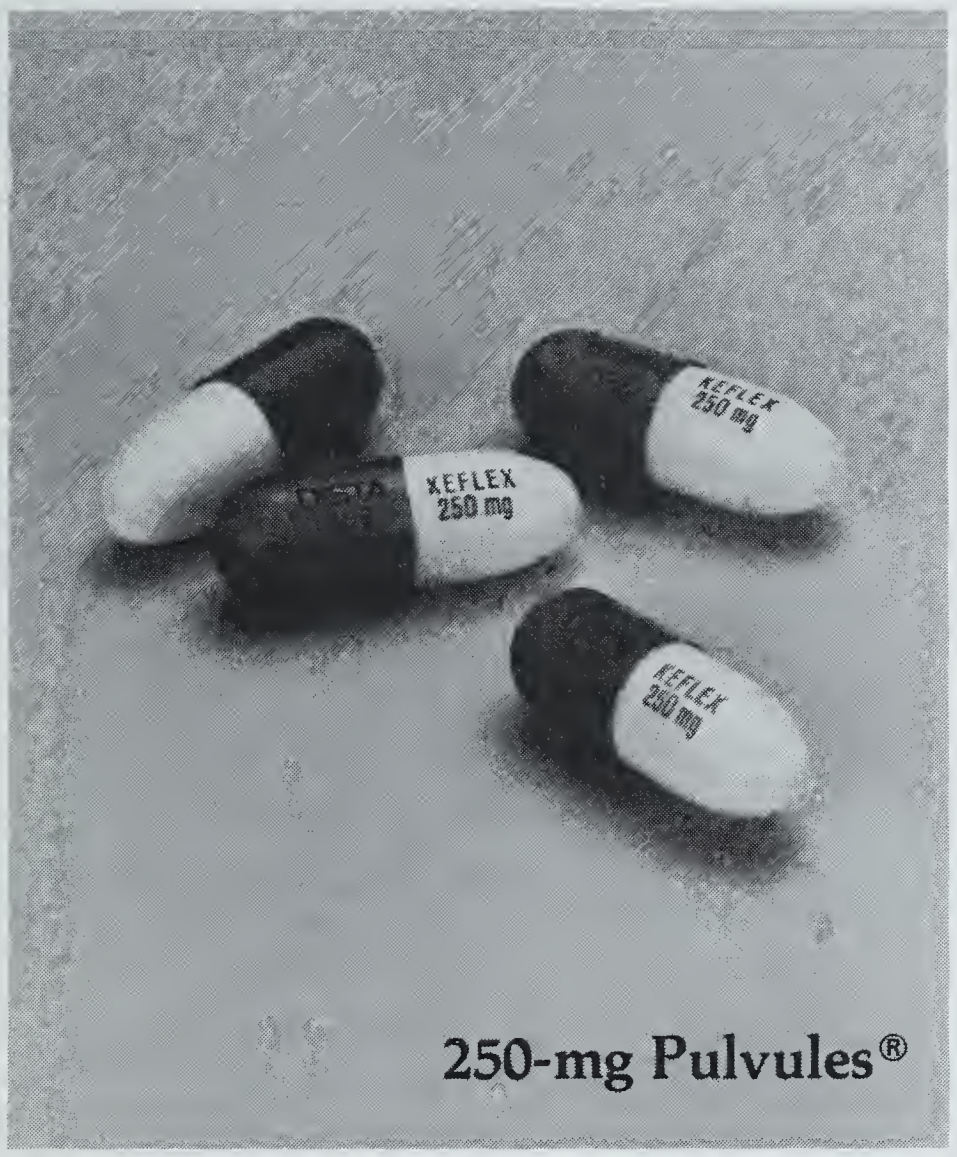

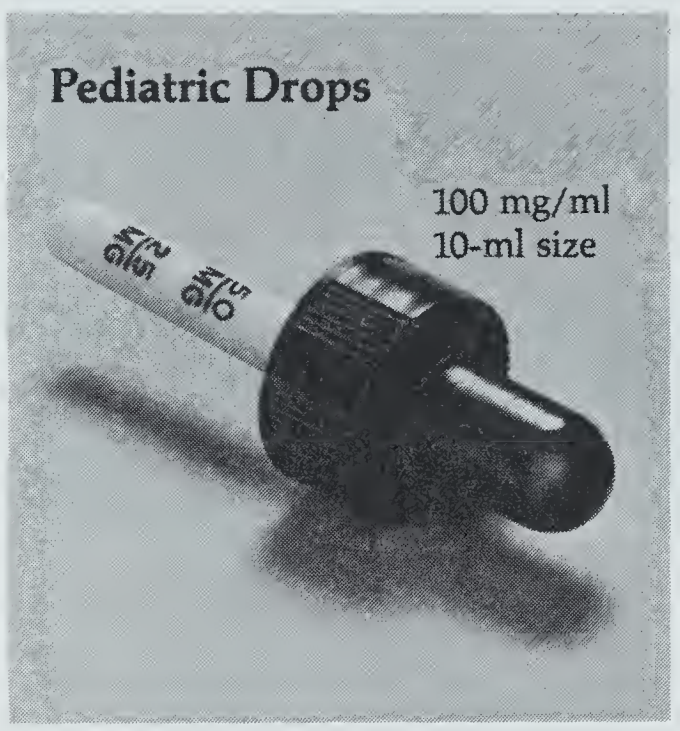

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PRESIDENT'S PAGE

The Strange Case of the Squeaking Wheel

J. Kendall Black, Jr., M.D.
President

Medicine, particularly organized medicine, has been accused recently of placing its selfish interests above those of patients — and above even the proper concerns of the profession itself.

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As a member of the Medical Association of the State of Alabama, you have many privileges and many forums in which to air your opinions. The routine meeting of the county society affords you the initial opportunity. If not as agenda item, certainly under new business, or as a point of personal privilege, the floor should be available to you.

Furthermore, the county society has Delegates and Counsellors to the business session of this Association. Delegates and Counsellors caucus to evaluate the agenda items and other business to come before the Association. As a county society, and as an individual in it, you have the privilege of addressing any issue you think pertinent. Furthermore, your county society has the option of instructing its Delegates and Counsellors as to the positions the society wishes them to take at the annual meeting.

At the state level, your Congressional District is represented by a District Censor, one of the seven who sit on the Board of Censors. There are also five members of the Board of Censors elected at-large from across the state. They are selected by caucus and elected at the annual session. I am sure a certain amount of political lobbying and campaigning goes on for their selection. By participating in that process, you select physicians whose opinions and ideas most closely represent those of the membership from your Congressional District.

On the third Wednesday of each month, the Board of Censors meets to direct the affairs of the Association. The Subcommittee on Association Affairs meets to consider agenda items prepared for it. This Subcommittee on Association Affairs meets to consider agenda items prepared for it. This Subcommittee consists of the President, the immediate past-President, the President-elect, the Vice-President, appointed members from the Board of Censors, and the Secretary-Treasurer.

The Subcommittee receives written communications from any member on any subject. Also, an individual member or a group of members may appear before the Subcommittee for presentation of items of importance to you. In recent months AMR, ophthalmologists, pediatricians and the Council on Medical Education have taken advantage of this privilege. Others have been invited to do so and will be heard from in the coming months.

Regarding the annual session, county societies may sponsor resolutions that will come before appropriate References Committees as well as the business session. Any member or a group may be heard at the Reference Committee meetings. Furthermore, any member with the endorsement of another member of his county society may request that any action taken by the Board of Censors during the year may be extracted and placed before our annual session with referral to an appropriate Reference Committee and reviewed during the business meeting. Another proposal to be heard at annual

continued on page 11

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Each prolonged action tablet contains: Phenylephrine Hydrochloride 25 mg • Phenylpropanolamine Hydrochloride 50 mg • Chlorpheniramine Maleate 8 mg • Hyoscyamine Sulfate 0.19 mg • Atropine Sulfate 0.04 • Scopolamine Hydrobromide 0.01 mg • Each Ru-Tuss tablet acts continuously for 10 to 12 hours.

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One tablet b.i.d. gives round-the-clock relief to adults and older children (12 years and over).

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TABLETS EXPECTORANT

RU-TUSS®
Tablets

DESCRIPTION
Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.
Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.
INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.
CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.
WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.
PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).
OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.
ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerotomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.
DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.
HOW SUPPLIED:

Bottles of 100 Tablets	NDC 0524-0058-01
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RU-TUSS®
Expectorant

DESCRIPTION
Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30
Phenylpropanolamine Hydrochloride	20
Pheniramine Maleate	20
Pyrilamine Maleate	20
Ammonium Chloride	200
Alcohol	

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and exp torant preparation.
INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of up respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rh tis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nc congestion and cough due to the common cold.
CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an o hypertensive or antidepressant drug containing a monoamine oxidase inhibito contraindicated.
Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma o in women who are pregnant.
WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient sho be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant r cause drowsiness. Patients should be warned of the possible additive effect caused taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.
PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicl operating dangerous machinery (See Warnings). Caution should be taken with pati having hypertension, diabetes, hyperthyroidism and cardiovascular disease.
Caution should also be used in patients with pulmonary, hepatic or renal insufficiency
ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddin dryness of mucous membranes, tightness of the chest, thickening of bronchial secreti urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, fa ness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xe stomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric tress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessn excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and e convulsions.
DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, nc exceed 10 teaspoonfuls in any 24-hour period.
Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoonfuls in 24-hour period Children 2 to 6 years of age: ½ teaspoonful every 4 hours, not exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use directed by a physician.
HOW SUPPLIED: (16 fl. oz.)

Pint Bottles	NDC 0524-1010

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EXECUTIVE DIRECTOR

A Censor's Many Duties

Many physicians seem to know little about the duties and responsibilities of the State Board of Censors. Often when Censors are elected, their physician/constituents expect their representatives to reflect their views only, to the exclusion of all others.

But when a Censor comes to Montgomery once a month, he puts on two other hats beyond that of the membership. He also serves on the State Committee of Public Health and on the Board of Medical Examiners.

In these capacities, he is constrained to make decisions according to law, representing the public as well as physicians. Often these interests — those of his colleagues, the requirements of the law, and the public — are not identical. At times, they are in conflict.

Accordingly, a Censor frequently feels himself pulled in three different directions at once. To do his sworn duty by all those from whom he is both judge and watchdog, he must often participate in some agonizing soul-searching over which of his roles shall be the paramount one on a given issue. Good men often disagree. That is one reason the Board is designed to arrive at a *collective* judgment, in much the same way a jury or grand jury is.

The great British statesman Edmund Burke, in a speech on conciliation with America in 1775, said it well:

"All government — indeed every human benefit and enjoyment, every virtue and every prudent act — is founded on compromise and barter."

There are few issues that are pure black and white. Often Censors are forced to make decisions where even the gray areas are poorly defined, as they weigh one interest against another. Those who would expect them to always represent only the interest of physicians, foresaking all others, would have to deny that doctors owe anything to the public. That is utterly contrary to the long tradition of public service on which MASA is founded, unique among state Associations.

A Censor, then, has a judicial role, charged with a high duty to his profession, his colleagues, the public, the law and tradition. In long thankless hours of deliberation, Censors have often come to understand poet's definition of Duty as "the stern daughter of the voice of God."

The English philosopher George Edward Moore, who died in 1958 at the age of 85, put it this way in his famous 1903 work on the principles of ethics:

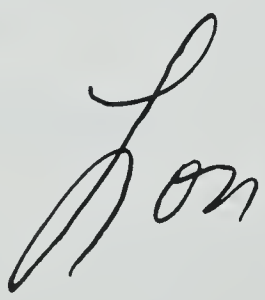
"Duty can only be defined as that action which will cause more good to exist in the universe than any possible alternative."

In America, we have translated this to read, as the basic principle of democratic government: The greatest good by the greatest number.

Finding that formula is not always the easiest task for the Censors you send to Montgomery.

Physicians who aspire to the job of Censor should be prepared to spend many a long and arduous hour trying to decide what their duty is. Like most things worthwhile in this life, that is not as simple as it may look from a distance.

S. Lon Conner



Dr. Black

ontinued from page 4

ession is one that would further open up the district aucus, allowing greater individual participation.

All of which is to say this:

Why waste your time *complaining* about the closed ystem? Instead of airing your grievances and giving ent to your opinons in the doctors' lounge and at linner parties, make your opinions heard where they count.

The silence of the membership at every level of organized medicine has been deafening, while opponents are highly vocal and highly organized. Two modern conveniences will assist you in telling your elected officers what you think — the U.S. Postal Service and Ma Bell. Call us. Write us. Come to see us.

The immemorial adage that the squeaking wheel gets the oil is only true if the squeaking is heard by those who do the oiling. Isn't it about time — to compound that awkward metaphor — that you begin to put your *shoulder* to that wheel?

We need you.

J. KENDALL BLACK, JR., M.D.
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In 1977, when the Veterans Administration compared Step-2 regimens in 450 mild hypertensive patients, which regimen was proven most effective?[1]

The Orchid Judge of Calhoun County

William H. McDonald

William E. White, M.D. (cover), allows that his obsession with orchids must have had its earliest genesis in his reading of the exploits of the great detective, Nero Wolfe, who grew orchids when he wasn't solving crimes.

But the most recent etiology was the atrium in the house he and his wife bought 15 years ago. After all, it had to be filled with plants. Orchids grew well, it was said, in such conditions.

In any case, the retired Anniston radiologist is unique in Alabama — he is the only Accredited American Orchid Society Judge in a state of more than 3.5 million souls.

The tall, gruff Dr. White confesses that he ''didn't know a petunia from a geranium'' when he started, and that his knowledge of horticulture was limited to cutting the grass occasionally. But he has risen to the top ranks of what is certainly the avant-garde of American gardening.

Part of the appeal, Dr. White muses as he looks out over the valley from his hilltop home toward the misty ranges of Cheaha Mountain to the South, is that orchid growing is impossible ever to conquer, even in several lifetimes. There are 900 genera, 30,000 species and perhaps 250,000 hybrids. Nobody has them all. He has 900 to 1,000, give or take a dozen — he long ago stopped counting.

The new house he and Mrs. White bought on a craggy lot back in 1966 was the beginning. The atrium was more of an immediate challenge than the backyard, which plunges downward at an angle approaching the vertical.

He was thinking of filling that atrium, centrally located in their modern, spacious home, with something suitable. Having spent most of his life poring over medical journals and texts, he found himself, one day 15 years ago, staring at a copy of *House Beautiful*. On the page before him was an ad by an orchid florist in Signal Mountain, Tennessee, not far as the crow flies North.

Hooked for Life

They went up on a weekend, knowing full well the florist would likely be closed. ''Won't hurt to look through the windows,'' Dr. White said in response to Mrs. White's objections of womanly practicality.

Dr. White had his nose pressed to the windows in Signal Mountain for perhaps 30 minutes when a man emerged to inquire as to his interests. Dr. White said he was interested in orchids, obviously. The man said that was his business. For the next couple of hours he took the Whites on a tour of his 15 greenhouses. Dr. White was hooked for life.

''I bought nine,'' he recalls. ''Since I didn't know anything about potting, or fertilizing, he showed me a few things. I got home and those nine orchids looked lonesome. There is nothing sorrier looking than an orchid that's not in bloom. After two or three weeks I went back to Signal Mountain and bought some more. Then I would go back every month or so until I had enough so there would be orchids in bloom all the time.''

Dr. White, as friends and associates will tell you, is an impatient man. He showed that when he blitzed other hobbies. Fishing, skeet shooting, turkey hunting, high fidelity, tropical fish — all have been worked over thoroughly by the White Method, best capsuled as total

nvolvement, with immediate conquest expected and demanded.

He was that way when he began his career in science, which eventually led to medicine. He liked science in high school in Anniston and went on to the University to study biology in the 1920s. Winning a scholarship to world-famed Marine Biological Laboratory, Woods Hole, Mass., he decided he wanted more. He went back to the University for his master's, winning it in 1929. Still, that wasn't enough. He went off to Columbia, where he enrolled in the Anatomy Department of the College of Physicians & Surgeons, earning his Ph.D.

He parlayed that into a junket to London, where he spent a year in the British National Institute for Medical Research. That started his medical interest. Thence to Harvard Medical, where he won his M.D. in 1937.

This Is the Army, Dr. White

He had been back in Anniston 18 months when World War II started. A reserve officer, he volunteered for active duty and spent the next five years in the Army. The Army experience dissuaded him from becoming a surgeon, forced him to be a pathologist, and convinced him to become a radiologist, in a complicated sequence of events and misadventures that took him to Europe with 28th Army Medical Laboratory and with the 8th Army into Tokyo after the Japanese surrender.

Discharged in 1946, he matriculated in postgraduate radiology at the University of Pennsylvania, thence home again, where he practiced in the old Anniston Memorial Hospital, which became the Northeast Alabama Regional Medical Center a few years ago. Dr. White retired in 1976.

He served on the Board of Censors and as MASA Delegate to the AMA.

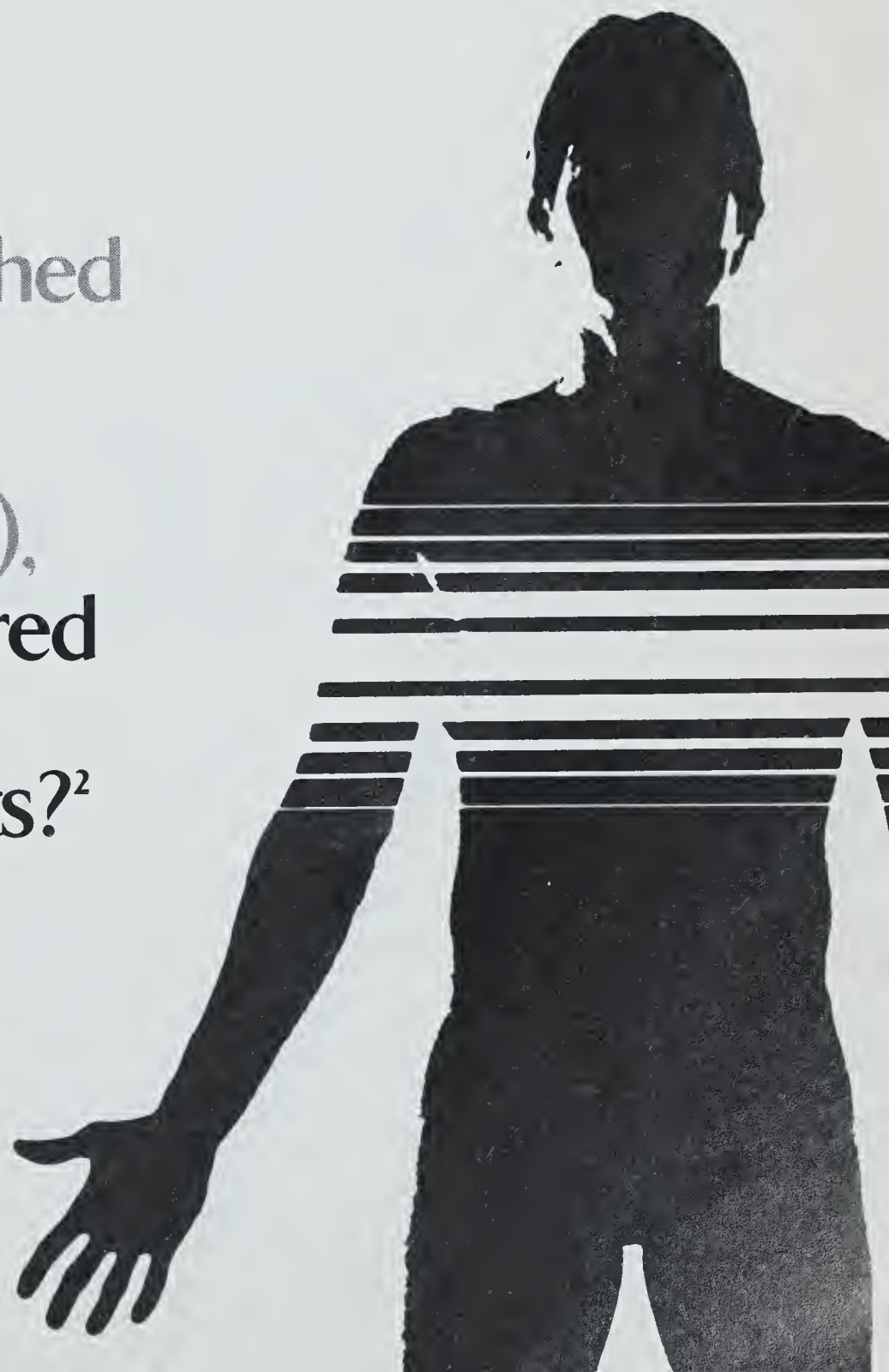
Orchids preceded, and followed, retirement. He has some thoughts on retirement for other physicians:

"For God's sake don't wait until you retire to get a hobby because I see too many of these poor devils who've retired, warm but dead. You need two hobbies at least — one you can do by yourself because you are going to *be* by yourself a lot, and the other you can do with your friends, because you *need* friends. I've preached that for many years. If you wait until you retire, believe me, you've waited too long."

Two greenhouses — and of course the atrium — pamper Dr. White's 900 or so orchid varieties, including some that have to be refrigerated at night to simulate the high Andes whence they came.

A bee somehow slipped into one of the greenhouses

n 1979, when results were published
or the five-year, 10,000-patient
Hypertension Detection and
Follow-up Program (HDFP study),
which Step-2 regimen was preferred
and was deemed effective
without significant adverse effects?[2]



when this writer was there. Dr. White was furious over the prospect of the orchid miscegenation that might result from the bee's random pollinization. He seemed at the point of going for his skeet gun when he finally chased the intruder out.

A Few Orchid Facts

Some incidental intelligences imparted by Dr. White in his peripatetic lecture on orchids:

• Some orchids are less than a millimeter in diameter. The public's taste, which runs to those "about the size of a bushel basket," is scorned and ridiculed by the pros, who admire most some plants many of us would scarcely regard as flowers at all. Dr. White grows them smaller than a pencil eraser and as big as a bushel basket.

• There is no such thing as a black orchid. The so-called black orchid is brown.

• The vanilla plant is an orchid.

• While orchids love the natural climate of the rain forests, parts of the Pacific Coast and South Florida, they will grow anywhere in the controlled environment of a greenhouse.

• There are 200 native orchids in this country, 98% of them terrestrial. Orchids are divided into two basic classes: terrestrial, growing in the soil; and epiphytes, growing on trees, stumps, anything, even rocks. Epiphytes are not parasites; they use their host for support but not sustenance. (This writer has no earthly idea where they get their sustenance, however, and didn't ask.)

• There are six or eight orchids native to the Calhoun county region.

• Most orchids prefer temperatures of 70 to 75 degrees, though the Andean orchids must have it mountain-cool, at around 50 degrees, for at least three hours every night. If they are not so chilled, they will not bloom.

• Apart from their general division into terrestrial and epiphytic, orchids may also be classified according to their preference for growing when the days are lengthening or when they are shortening. To which Dr. White adds a third sub-class from his own experience: "Some bloom whenever they damn well please."

Orchid Intern, Resident, Etc.

To get to be an orchid judge, you've got to know your stuff. Even then the apprenticeship is long — five years of recognized growing before you may apply for a student judgeship; three years of successful judging in this capacity before you can win the coveted but revocable title of orchid judge, probationary status.

After three years of probationary judgeship, during which time you must attend at least eight shows a year, you may apply for the pinnacle — Accredited American Orchid Society Judge. If elected by the Society, you may then pick your shows, so long as you attend at least eight a year, and nobody can take the title away from you.

Accredited American Orchid Society Judge William E. White, M.D., Ph.D., takes in about 10 a year, from South America to Detroit. One year, just to show his versatility, he also served as President of the Birmingham and Atlanta orchid societies simultaneously.

On the way up, he won top national awards for botanical merit and best of show, evidence enough that he had not let his horticultural amateurism deter him from competing with the best of them. He names all of his hybrids after his wife, Elise.

But he doesn't compete now that he is a judge. He believes in always moving forward.

Never Look Back

"I never was anything for going back. If I dropped something, I want it to stay dropped. I used to breed tropical fish, but I quit. I used to shoot skeet, but I quit. I never go *back* to anything, but I will go *on* with orchids. Where, I don't know."

Dr. and Mrs. White are happy in his retirement, with their consuming interest in promoting orchid growing. But together they see a real problem for others:

"Somebody who takes an interest in orchids really has no one to learn from here in Alabama. The books are mostly over the head of the beginner. You don't know where to find a decent journal. It's tragic. The only way to learn is to get involved: join an orchid society."

After saying goodbye to his visitor, Dr. White walked briskly to his house in the sharp fall light. He did not look back.

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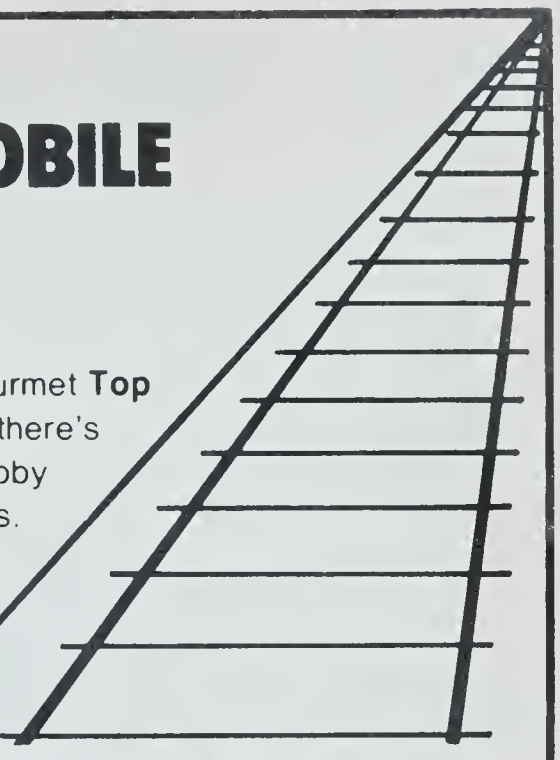

GET ON THE TRACK FOR FALL 1981

It started in 1898 as the Western of Alabama Freight Depot. This wonderful old depot in the heart of Montgomery's Historical District has a new purpose. By fall of 1981 it will become a most unique hotel. Adjacent to the Civic Auditorium and Alabama River, the Sheraton Riverfront Station will feature two restaurants, two lounges, meeting rooms, and the most unique guest rooms you've ever seen. Put your clients on the right track. Reserve Montgomery's historic hotel. Open October 1981.

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In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?[3]

New Uses for an Old Test: The Schilling Test

W. Roger Carlisle, M.D.

Introduction

As new methods of radiodilution assay for vitamin B12, R proteins and total cobalamins have become more sophisticated, there have been suggestions that the Schilling test will become obsolete. This article will remind everyone that the Schilling test, not only is diagnostic in pernicious anemia, but can be used to diagnose and follow terminal ileitis, bacterial overgrowth, pancreatic insufficiency, blind loop syndrome, gastrectomy and latent pernicious anemia. Vitamin B12 deficiency and malabsorption is a very common problem seen in elderly patients and in general practice. This vitamin requires endogenous intrinsic factor for absorption and is actively absorbed in the ileum. The clinical manifestations are listed in Table I.

Physiology

Cobalamin is ingested attached to dietary protein. The Cobalamin is attached to R binders in the saliva and gastric juice. These R binders have increased affinity for Cobalamin at an acid pH.[1] Pancreatic proteases also degrade R protein and reduces Cobalamin affinity. The Cobalamin intrinsic factor then travels the length of the small intestine and is absorbed in the terminal ileum by a specific receptor. Attachment of this complex to the ileum requires calcium and a pH of 5.6.[2] The Cobalamin is then attached to transcobalamin II in the ileal cell for transport. Then Cobalamin circulates in the blood largely bound to R binders. Man contains three

TABLE I

	Stage I *Cobalamin*	*Stage II* *Cobalamin + IF*	*Stage III* *Cobalamin + Pancreatic Enzyme*	*Stage IV* *Anti-biotics*	*Stage V* *Anti-helminthic*
Pernicious Anemia	Abnormal	Normal*	Abnormal	Abnormal	Abnormal
Pancreatitis	Abnormal	Abnormal	Normal*	Abnormal	Abnormal
Bacterial Overgrowth	Abnormal	Abnormal	Abnormal	Normal*	Abnormal
Tapeworm	Abnormal	Abnormal	Abnormal	Abnormal	Normal*
Ileal disease	Abnormal	Abnormal	Abnormal	Abnormal	Abnormal

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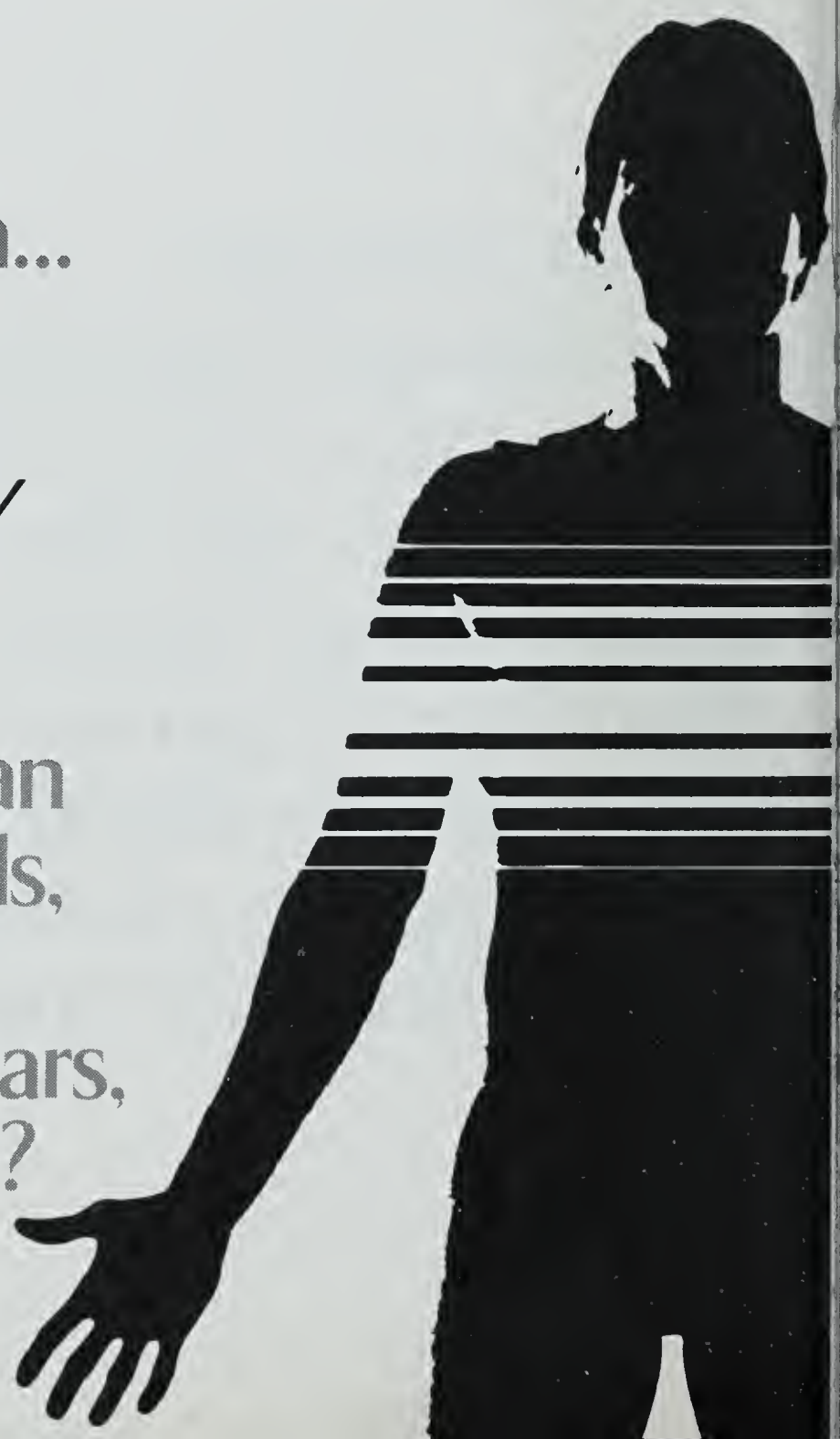

nain Cobalamins: hydroxocobalamin, adenosylcobalamin nd methylcobalamin.[3]

Laboratory Evaluation of the Patient

Vitamin B12 absorption may be abnormal for four to six ears before clinical symptoms are seen. Thus, we are seeing requent cases of latent pernicious anemia (LPA) in which no nemia is present. Vitamin B12 status is evaluated primarily y three tests: RBC indices, assay of Cobalamin blood evels, and the urinary excretion test (Schilling test). It is ery important to realize that serum B12 levels tend to over stimate true B12 levels beause radioisotopic assays measure umerous metabolic inactive Cobalamins and Cobalamins ound to R protein. Therefore, borderline low "serum B12" evels are often significant. Numerous reports of misleading econd state Schilling tests have also been reported due to lefective commercial intrinsic factor preparations.[4] An bnormal second state Schilling generally suggests bacterial vergrowth, small bowel disease, or pancreatic disease.

However, this test is frequently misleading due to: (1) ailure to digest the IF-capsule, (2) defective commercial IF, 3) biologically active antibodies to IF, (4) severe Cobalamin leficiency which causes malabsorption by the ileum, and (5) combined effect of bacterial overgrowth and pernicious ane- nia.

I frequently use a Schilling test to follow therapeutic esponse in Crohn's disease and to evaluate bacterial over- growth in the elderly. Small bowel anaerobic cultures and ydrogen breath tests are often difficult to perform in the lderly. The differential Cobalamin test can be done in V stages (Table I). The sequential addition of intrinsic factor (Stage II), pancreatic enzymes (Stage III), antibiotics (Stage IV), and antihelminthics (Stage V), will define the deficiency which is causing B12 malabsorption.

Etiology of B12 Deficiency and Clinical Evaluation

The etiology of B12 deficiency is summarized on (Table III). In clinical practice most B12 deficiencies are due to bacterial overgrowth and pernicious anemia. Bacterial overgrowth is very common in the elderly and usually presents an unexplained weight loss.[5] These elderly patients, reported by Roberts, had low gastric acid, reduced intestinal motility, macrocytic anemia, osteomalasia and abnormal 14 C-glycocholate breath tests. If patients are found to have abnormal Stage I and Stage II Schilling tests, then treatment with pancreatic extracts and Tetracycline (Stage III-IV) should be tried to diagnose and treat possible pancreatic insufficiency or bacterial overgrowth. The etiology of B12 deficiency should be pursued with a small bowel series which may show

TABLE II
MANIFESTATIONS OF B12 DEFICIENCY

Mental changes
Macrocytosis, 2° deficiency tetrahydrofolate (↑ MCV)
Sore tongue
Anemia
Weakness
Defect in myelin sheath
Tabacco amblyopia (elevated chinocobalamin)
Paresthesias, ataxia, weakness
Combined system disease

nd there's more proof on the way!

82 will see the completion of the Multiple Risk ctor Intervention Trial (MRFIT)—a six-year, ,000-patient study assessing the factors that crease risk of cardiovascular disease. For the anagement of hypertension, the preferred ep-2 regimen in this study is reserpine-thiazide.

1978, in a preliminary report presented to the idemiology Section of the American Heart ssociation (Dallas, Nov 1978), after 12 months the trial, fewer patients (5.3%) treated with serpine suffered depression than even the ntreated control group (7.7%)!

e see references and brief summary of prescribing information on last pages of this advertisement.

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☐ Journal article reprints of the clinical studies mentioned in this ad

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SM-2348 11/81

TABLE III
B12 DEFICIENCY ETIOLOGY

(1) Intrinsic factor deficiency (stomach)
  A. Normal HCL
  B. Biologically inert intrinsic factor (BIIF)
  C. Pernicious anemia
  D. Type A gastritis
  E. Congenital intrinsic factor deficiency (CIFD)
  F. Ablative gastric surgery
  G. Intrinsic factor antibody
(2) Pancreatic insufficiency (R protein binding)
(3) Dietary (vegetarian)
(4) Release from dietary protein (Tagamet)
(5) Binding of cobalamin to R binders
(6) Small bowel disease — diseased or resected T. Ileum
(7) Bacterial overgrowth
(8) Fish tapeworm
(9) Ileal receptor and transport deficit (small bowel)
  A. B12 or folate deficiency
  B. Diseased ileum
  C. ZE syndrome
  D. Defective intrinsic factor
  E. Familial selectove cobalamin malabsorption
  F. Transcobalamin II deficiency
(10) Drugs — colchicine, alcohol, Pas, neomycin

Crohn's disease, small bowel diverticuli, reduced motility or blind loops. Tapeworms and other causes should be considered. A 14 C-glycocholate breath test will often diagnose bacterial overgrowth. A low folate or steatorrhea suggests more extensive small bowel disease or malabsorption.

Treatment

The treatment of B12 deficiency depends on the etiology and require accurate diagnosis. Usually it is safest and most cost effective to prescribe vitamin B12, 100 mgm., I.M. monthly for life. Hydroxocobalamin, not cyanocobalamin, is the form of vitamin B12 most suitable for therapy. It is often more cost effective to continue B12 therapy rather than to check frequent B12 levels or Schilling tests.

Summary and Recommendations

1. Laboratories should not store IF preparations for long periods and do not use encapsulated preparations.
2. Labs should check accuracy of Stage II Schilling and delay second stage test six months if PA is pronounced.
3. Stage II Schilling and serum B12 levels should be interpreted with caution.
4. Hydroxocobalamin is the preferred therapeutic agent for treatment of B12 deficiency.
5. Remember, bacterial overgrowth is very common in the elderly and frequently causes abnormal Schilling tests.
6. B12 levels are often normal in pernicious anemia since malabsorption may be latent for years.
7. The Schilling test has many uses other than just evaluating pernicious anemia.

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Salutensin® **Salutensin-Demi™**

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78

For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

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ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

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DMSO, Dimethylsulfoxide, An Overview

Richard T. Herricks, M.D.

DMSO was initially discovered by Dr. Alexander Saytzeff in Kazan, Ukraine, Central Russia, in 1866, and has been used throughout the world, especially in the United States, since the 1950s, as an industrial solvent. It has a very simple structure of SO (CH3)2, with a freezing point at 18°C boiling at 189°, however 50° below 0 Centigrade a 50% solution with water will not freeze.

Because of the possibilities of decreasing inflammation, Robert J. Herschler, in 1961, Supervisor of Research for Crown-Zellarbach Corporation tried DMSO on a chemical burn on himself, which relieved the pain in 4 hours. He then reapplied it, and it again took away the pain. He contacted Stanley Jacob, M.D., Assistant Professor of Surgery, University of Oregon Medical School who was also experimenting with DMSO, and they thereafter worked for several years together.

They used it on sprained ankles, which relieved the pain in 15 minutes, as well as osteoarthritis of the thumb, headaches, cold sores, and juvenile rheumatoid arthritis, and in almost all cases quickly relieved the pain dramatically.

It was distributed as Dymasol by Zirin Corporation in 1964, and in 1965 Merck, Sharp, and Dohme did clinical studies on over 4,000 patients with good results with acute inflammatory problems. Specifically, a 70% solution utilized produced relief with acute bursitis, lumbosacral strain. When they switched to a 90% solution, they got an even faster, more complete relief of pain and swelling, even with rheumatoid arthritis.

P.O. Box 4160, Opelika, Alabama 36801.

With Dupuytren's Disease there was improvemen with a 90% solution with almost half of their patients but it had to be used for over 6 weeks.

In 1965 Squibb studied over 1900 patients with ar 80% and 60% improvement, respectively, in acute and chronic arthritis and bursitis.

In November 1965, the FDA halted research since some animals developed ''myopia'' but not cataracts what with a refractive index change, in doses over 100 times that used in human adults.

Jacob and Herschler reported, in 1964, that DMSO significantly reduced edema in guinea pigs with burns that it was a bacteriostatic agent in a 20% concentration against E. coli staph aureus, and pseudomonas, and reported the aforementioned findings with acute and chronic musculoskeletal injuries, also in 1964. Several papers given before the American Rheumatism Association, in 1964, showed better results, or at least equal to those using Salicylate, and also reported considerable pain relief with range of motion improvement to normalcy, with adhesive capsulitis of the shoulder.

In 1965, at the 20th Annual Meeting of the American Society for Surgery of the Hand, Dr. Jacob presented an article on ''The Use DMSO in Acute and Chronic Musculoskeletal Injuries and Inflammation of the Hand.''

Also in 1965 they reported more animal studies as well as human use of DMSO with burns, especially chemical burns, acute subacromial bursitis with dramatic relief of pain and spasm within 30 minutes, with persistent results applying it 3 or 4 times a day.

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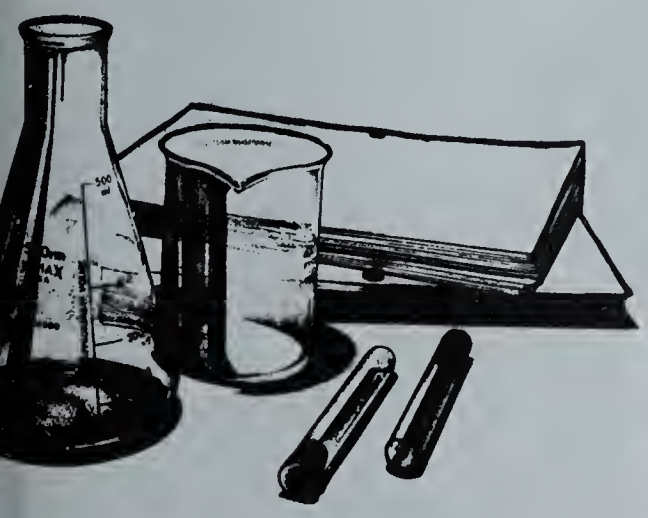

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5/81

RF-009

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(For full prescribing information, see package brochure.)

RUFEN® Tablets
(ibuprofen)

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

They also used it for osteoarthritis of the hand, and rheumatoid arthritis of the hand, but with less dramatic results.

It often took several months to get decent results.

With Duputyren's contracture, two to three week period of treatment usually produced softening of the fascia, with increased range of motion, but never with complete recovery of contractures.

They also reported about 5% of over 500 patients with an increase in skin pigmentation but which returned to normal after discontinuation. There was about a 2% incidence of dermatitis requiring discontinuation of therapy.

In 1965 Kligman reported healing aschemic ulcers of the fingertips at the Cleveland Clinic, and others reported promotion of continuous penetration through the skin, of corticosteroids and also noted that the Straham corneum was the chief rate limiting barriers to percutaneous penetration.

They were able to increase penetration of Declomycin within minutes, and also showed that DMSO did not produce a permanent, irreversible change, in the horny layers permeability.

They were able to get at least partial anesthesia to pin prick with 50% solution, but showed that the nail plate could not be broached by DMSO.

They also reported that the histamine-liberating effects of DMSO produced the side affects of burning, occasionally, especially with 90% solution.

They reported no incident of allergic sensitizations, and that the vesiculating effects of the DMSO stopped abruptly when the concentration was reduced to 80%.

Further studies reported in the Veterinary Medicine literature showed that DMSO is a voluntary muscle relaxant, and it again was reported that its greatest value in gout was with chronic gouty arthritis, but took several months for results, especially in the hands.

Post-mastectomy lymphedema of the upper extremity in ⅔ of their patients improved after at least 2-3 weeks of therapy.

In 1966, there were some reports of DMSO increasing tensile strength in wound healing in rabbits, but no report on the use in humans.

Because of this, other studies were done using DMSO with scleroderma and at least one report showed no improvement, in spite of earlier reported successes.

A definite success was the use of DMSO with Thiabendazole in treating creeping eruption, larva migrans, and much less painlessly.

In 1966 the New York Academy of Sciences had a symposium on DMSO with 82 papers, none of which were negative, several of which showed very good results.

It did report that often the beneficial results were unpredictable, but often dramatic, and especially in acute conditions.

Some were able to obtain long acting anesthesia with tetracaine, and there was a 77% good results with pain relief in rheumatoids, and with acute tendonitis, and 88% improvement with neuritis.

Forrest Riordan, M.D., of Rockford, Illinois, used DMSO in over 50 hand patients, especially had success with frostbite.

J. Adamson, M.D., used DMSO to keep flaps alive, and thought that it increased the success rate.

It is also reported that the half-time DMSO in the blood is greater than 10 hours, but it often had to be applied several times a day to get good results.

Further investigators showed that it seemed to lower conduction velocity of nerve impulses in at least frogs.

DMSO was also reported to inhibit the growth of fibroblasts in tissue culture and protect against lethal doses of x-rays in mice.

Also in frogs and mice, as a concentration of DMSO is increased, the apparent oxygen consumption in skin is reduced.

DMSO was also reported to increase the penetration of both hydrocortisone and testosterone by 3 to 6 times normal penetration, in man.

In 1966 a symposium was held at the University of Vienna Medical School, which again reported no problems with eyes in humans, and again about a 77% improvement in rheumatoids, and they also stated that it was better than anything else they could find for acute sports injuries.

The equivalent of 1 to 2 pounds of DMSO a day apparently would be necessary to do damage to the human eye, according to this study, and following this, on December 22, 1970 a patent was issued for DMSO.

In the meantime, more reports verified about 80% at least partial relief in acute musculoskeletal conditions, including sprains and strains, but always with less satisfactory results with rheumatoid arthritis, and which required longer periods of treatment.

They again repeated the results of therapy resisted subacromial bursitis doing much better, and again reported half the patients with a distinct and characteristic taste in the mouth.

Nineteen patients were evaluated and again showed approximately 70 to 80% improvement in acute conditions, with about a 5% discontinuation because of local irritation when utilizing 90% solutions.

Several studies seem to show that DMSO preferentially blocked conduction in the smaller peripheral nerve fibers first, diminishing the central response to stimulus which ordinarily causes pain, thus elevating the pain threshold.

Herpes zoster was treated with DMSO with idoxuridine, with statistically significant accelerated healing.

A newer paper on the treatment of scleroderma showed not only no evidence of ocular damage, lessening of flexion deformities and definite relief of pain with increased motion, but phenomenal regrowth of hair, even on the scalp.

Approximately 80% of the patients also started sweating for the first time in several years, all had healing or increased healing of persistent ulcers, and return of senstaiton but with no signs of arrest of systemic disease.

There is apparently overwhelming tendency of carbon 14-DMSO, to be confined to the interstitial spaces.

Several papers presented at the 3rd International Conference on DMSO, in San Francisco, 1975, again reported good results, particularly in acute diseases, especially inflammatory, sprains and strains, and again showed no eye damage.

Many people have mild erythema and itching with the 70 to 90% solutions usually used, but with no permanent damage.

Fourteen day controlled studies of toxicity in humans did not produce any adverse effects, including studies with regard to liver function, renal function, skin changes and ocular problems.

Gas chromatography of the blood showed that DMSO penetrates more quickly into the blood vessels from the skin surface, and that there is an increase in the excretion of hydroxyproline in the urine of patients with scleroderma.

By April of 1971, you could buy DMSO by prescription in Russia, and several countries thereafter allowed the use of DMSO, with prescriptions, including West Germany, Austria, and Switzerland for shingles and other viral diseases, Canada for scleroderma, Great Britain and Ireland for shingles, herpes, etc., China for scleroderma, and Poland, with hydrocortisone, for neurogenic pain, on an experimental basis.

In 1977, Morales reported over 100,000 patients treated with DMSO IV without incident, however there have been some reported renal failure with IV administration, especially in elderly.

In 1977, Israel used DMSO to treat amyloidosis, with very good results, as reported in the *Lancet*.

Also in 1979, very good results with DMSO treating amyloidosis, was reported from the Netherlands, with remarkable recovery from amyloid-induced end-stage renal failure with a suggestion of a decrease in amyloid fibril formation.

At least 50% of the patients get a garlic-like taste and odor of the breath, due to DMSO metabolite, but all of which quickly disappears upon cessation of use.

In addition to maceration, scaling, and dermatitis, other reported side effects have included headache, nausea, diarrhea, dysuria, and rarely, photophobia.

The *FDA Bulletin* in 1980 advises that DMSO "has not been shown to be without risk of eye injury." It doesn't say whether this is with humans, animals or what.

Available in the gel form, with wintergreen, helps mask the odor, but this is available for humans only in Oregon.

In Sweden and West Germany, it is often injected, intra-articularly and often in conjunction with various steroids.

It is also used with local anesthetics, for injection into soft tissues, or simply spread on the skin, especially for weight-lifters.

Epidermal scars inhibit the solubility of permeability of DMSO through the skin, but it has been used successfully to treat hypertrophic scars and keloids.

In the event of overdose, DMSO is strongly bound to plasma proteins, therefore clearance by hemodialysis or peritoneal dialysis is very poor.

It has been reported to be used by a vast majority of collegiate runners, football players, wrestlers, and in other sports.

A large problem is, however, that since it is essentially odorless it often cannot be picked up if mixed into other solutions, sold and mislabeled.

Also it is an excellent solvent for rayon, vinyl and acrylics. It can, therefore, dissolve clothing, and perhaps even produce problems in this way, if clothing is placed over the DMSO while still present on the skin.

Since it is still legal in Oregon, the Health Sciences Center in Portland is reportedly treating over 200 patients per week with multiple problems, with very good results, and very few side effects.

It is also used in conjunction with anti-coagulants, as well as anti-inflammatory drugs including corticosteroids, not only for amyloidosis, but for hematomas, ecchymosis, etc.

Certainly DMSO is not absolutely safe, which would imply that it would probably be totally ineffective. However, since it is logical that a drug should be safe as reasonable precautions by all concerned can make it, consistent with appropriate therapeutic benefit, it probably fits these criteria.

A very recent study has shown that DMSO may be beneficial in the treatment of myasthenia gravis, by reducing the number of antibodies characteristically present.

Research at Johns Hopkins reported that they knew of no current treatment that reduced the circulating antibodies as quickly, safely, and as effectively as the DMSO did in their experiments with mice.

DMSO has been reported to inhibit the metabolism of sulindac (Clinoril); therefore, suggest caution in using both concurrently, although several athletes do.

Finally it has been reported that a 64-year-old businessman for 12 years drinking approximately ½ teaspoon a day of 99% DMSO as a cure-all!

This is reminiscent of the story of a doctor in an opera, which was recently published in the *Southern Medical Journal,* which quoted the lines of Dr. Dulcamara telling the villagers about his love potion:

The cure for all and sundry
Is the medicine I have got.

For all complaints cholerical
Dyspeptical, arthritical,
Asthmatical, hysterical,
Bronchitical, paralytical,
Rheumatical, scorbutical
Of pellicel and cuticle,
And all the smartest illnesses
Which folk in town have got,

The med'cine that I'm selling
Will cure you like a shot.

Entities on Which DMSO Has Helped

1. Supraspinatus tendonitis
2. RSD (PTSD)
3. Boutonniere deformity
4. Ulno carpal strain
5. Hamstring pull
6. Trigger fingers
7. Trochanteric bursitis
8. AC Joint Osteoarthritis
9. Multifidus strain
10. Patellar tendonitis

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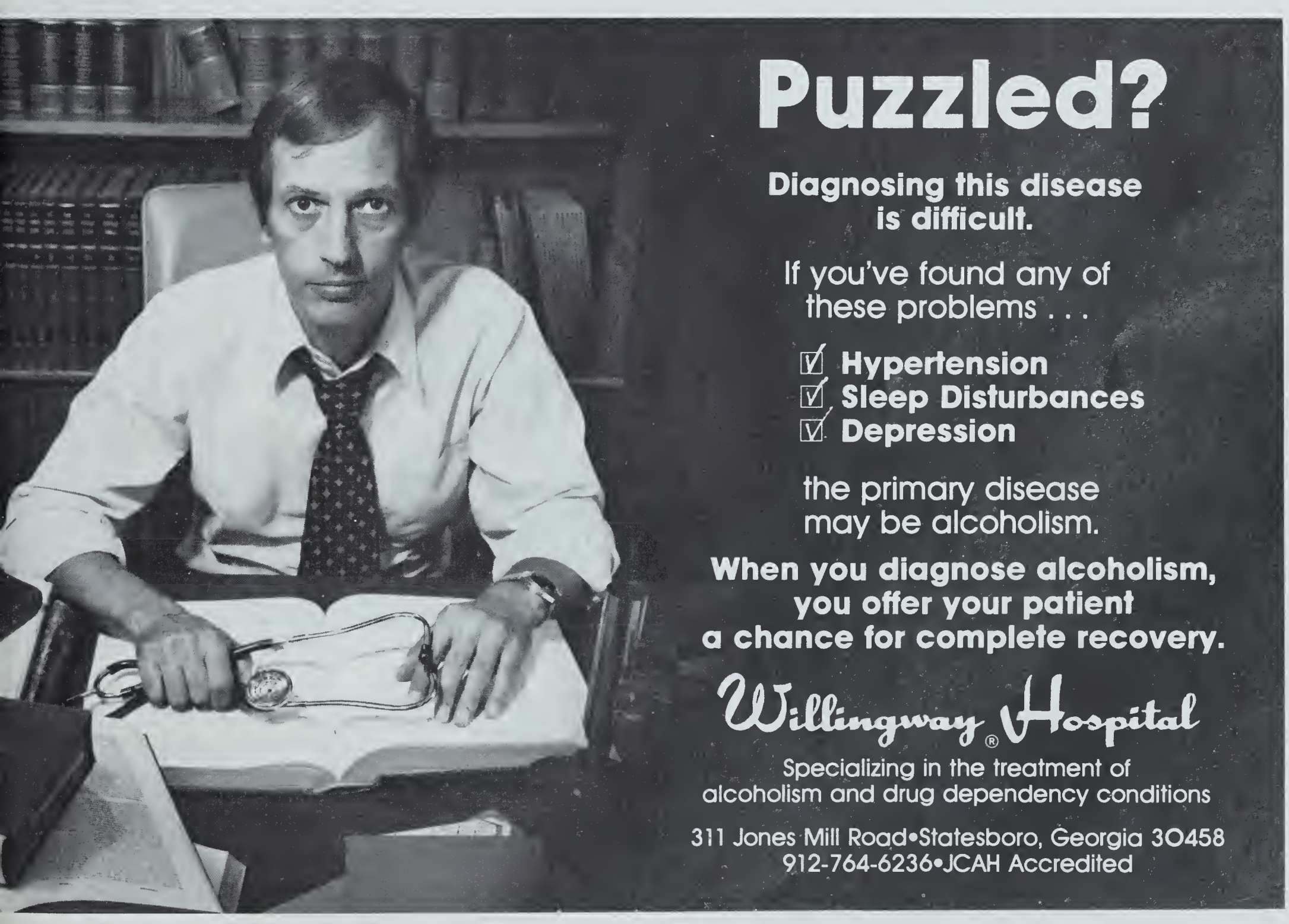

Acute Lower Extremity Ischemia Due to Ergotism

Ishwar Bhuta, M.D., Montgomery, Alabama

A Brief Case Presentation

Food born sporadic and epidemic Ergot poisoning has been known for centuries and has been reported as recently as 1953.[7] With the introduction of Ergotamine Tartrate in 1962 by Maier[17] for treatment of migraine, most cases of ergotism reported in literature have been iatrogenic. The most severe complications have been marked arterial vasospasm, commonly in the vessels of the upper[3, 11] and lower extremity.[21, 23] Although spasm of other vessels such as renal,[26] carotid,[5] mesenteric[12, 20] and retinal[15] have been reported.

Case Report

The patient was a 39-year-old white woman who was admitted to St. Margaret's Hospital on June 29, 1977 because of progressive pain in the lower extremities of seven days duration. One day prior to admission the pain was severe and constant even at rest. Two days prior to admission she had taken six to eight Cafergot (Ergotamine-Caffeine preparation) for a headache. She took four Cafergot a day prior to admission as analgesic for leg pain.

On physical examination she was tossing in bed because of severe rest pain in the right leg. She had a blood pressure of 150/90 mm of Mercury. The femoral pulse was absent on the right side and a faint femoral pulse was noted on the left side. The right popliteal and pedal pulses were absent. The left popliteal was present and the pedal pulses were absent. Dorsiflexion of the foot caused marked pain in the calf muscle. The right foot was cyanotic and the venous filling was poor. The pedal pulses could not be detected with the Doppler instrument. A left transfemoral arteriogram was performed within a few hours of admission. There was severe constriction of the right iliac and right and left superficial femoral arteries. The patient was suspected to have Ergot induced ischemia and was given 75 mgs of Priscoline (Tolazoline) in the terminal aorta. Two hours later there was no improvement and right lumbar sympathetic block was given using 1.5% 10 cc's of Xylocaine by the anesthesiologist at the level of L2 and L3 spine. Right femoral pulse became faintly palpable

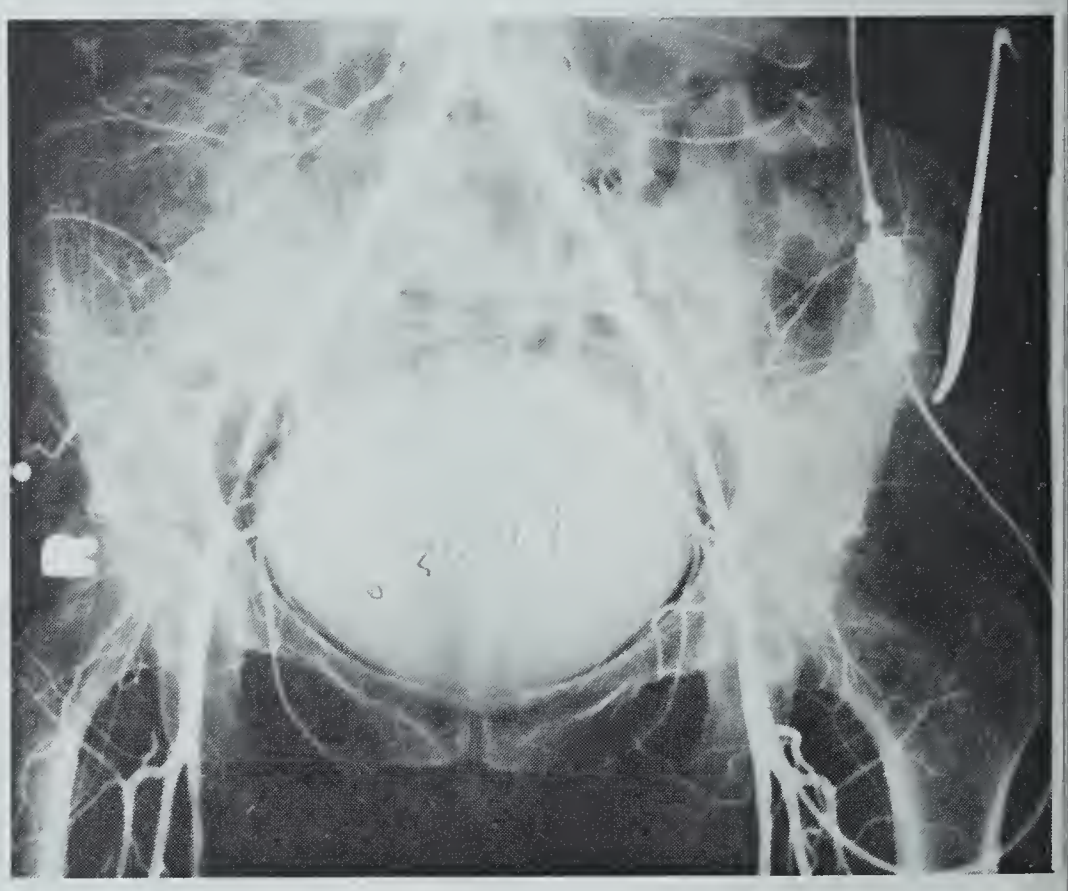

Figure 1. Aortogram —segmental spasm right external iliac artery.

with a bruit. The left pedal pulses also became palpable. The right foot was still cyanotic without any pedal pulse on Doppler examination. Twelve hours after admission the status remained the same and the patient's femoral artery was explored. A number four embolectomy catheter was passed proximally and dis-

First Class First Aid

Recommend

NEOSPORIN® Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

- Broad-spectrum antibacterial
- Handy applicator tip

DESCRIPTION: Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and ½ oz and 1/32 oz (approx.) foil packets.

INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome / **Burroughs Wellcome Co.**
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Motrin® vs aspirin w/codeine...
(ibuprofen)

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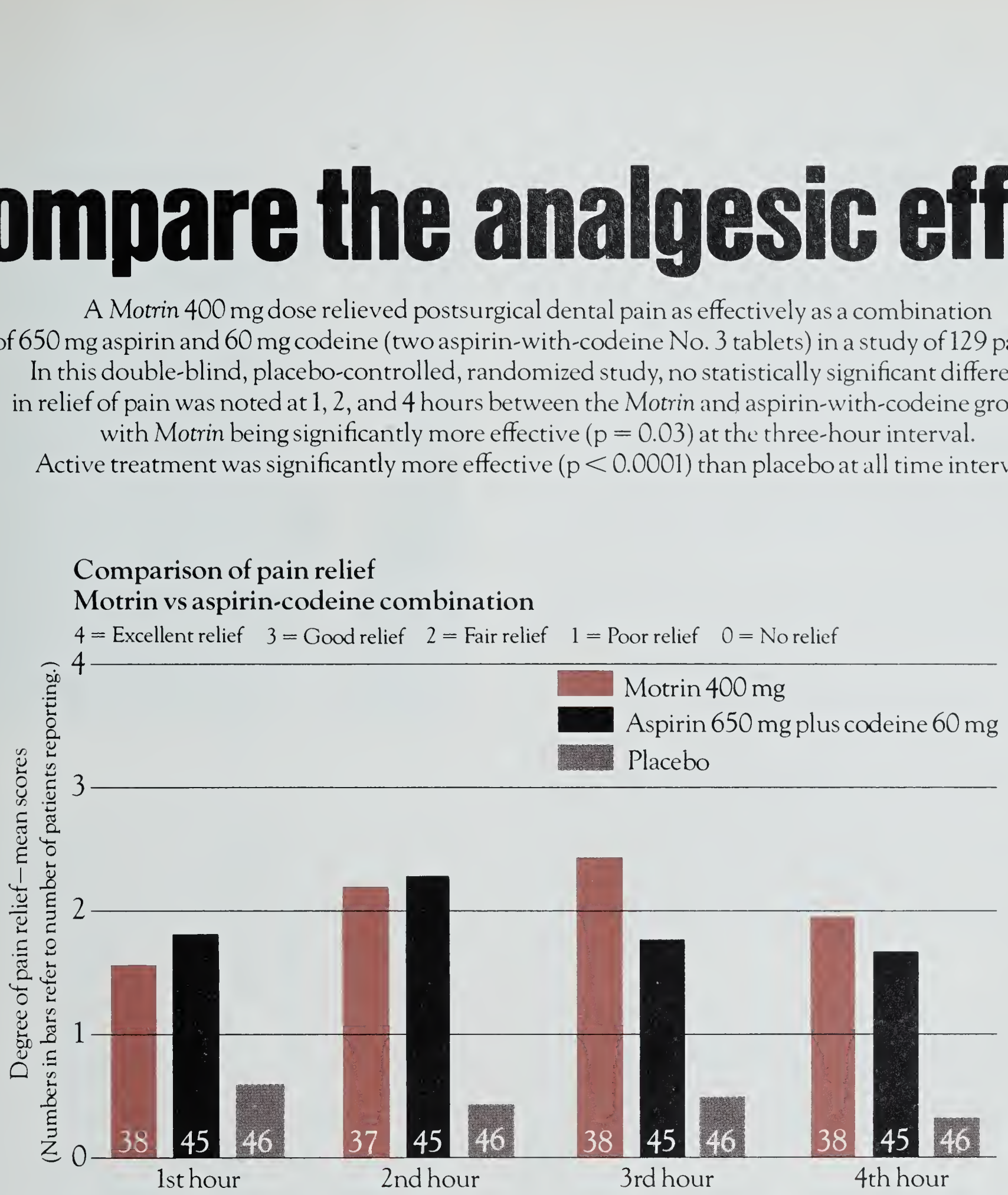
compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea;* epigastric pain;* heartburn;* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness;* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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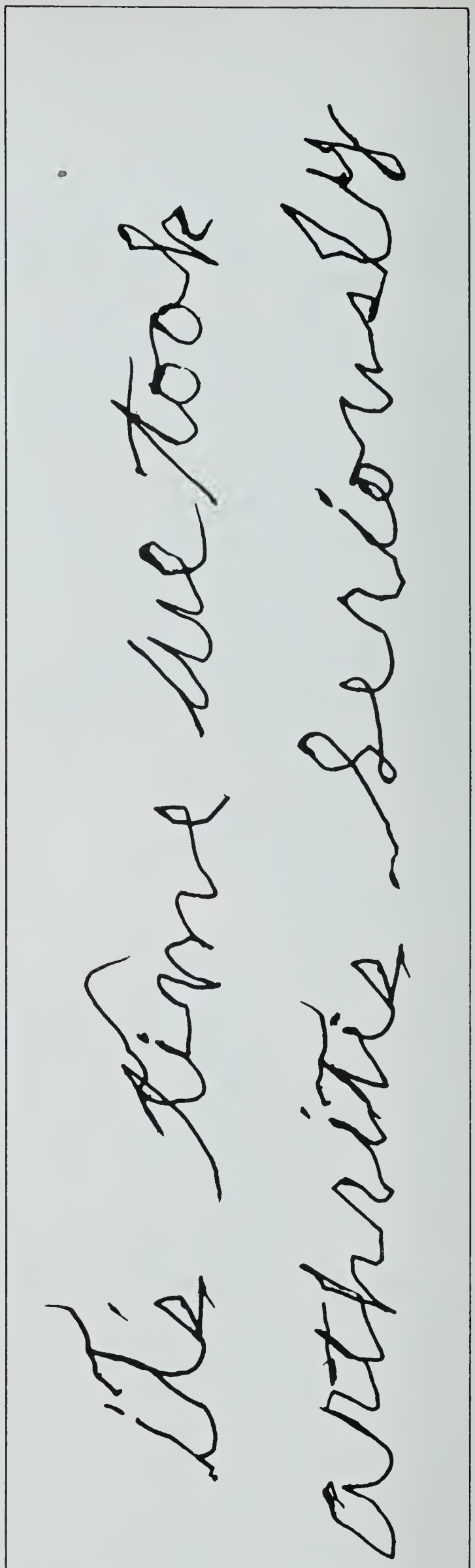
MARCH 1981



It's a myth that arthritis is just the minor aches and pains of old age. It's a major crippler that attacks. Anybody. Anytime. 31 million Americans have it. There are almost a million new cases a year. And six out of ten are under 60. Symptoms can come and go for years. So if you don't know the warning signals, find out. If you'd like information that could help you—or you'd like to help us—write to the Arthritis Foundation, Box 19000, Atlanta, GA 30326.

ARTHRITIS FOUNDATION

tally without recovery of clots. Intra-arterial Priscoline (Tolazoline) 75 mgs and Xylocaine 100 mgs was given and the patient was kept Heparinized. The next day the pedal pulses were easily palpable on both sides and at

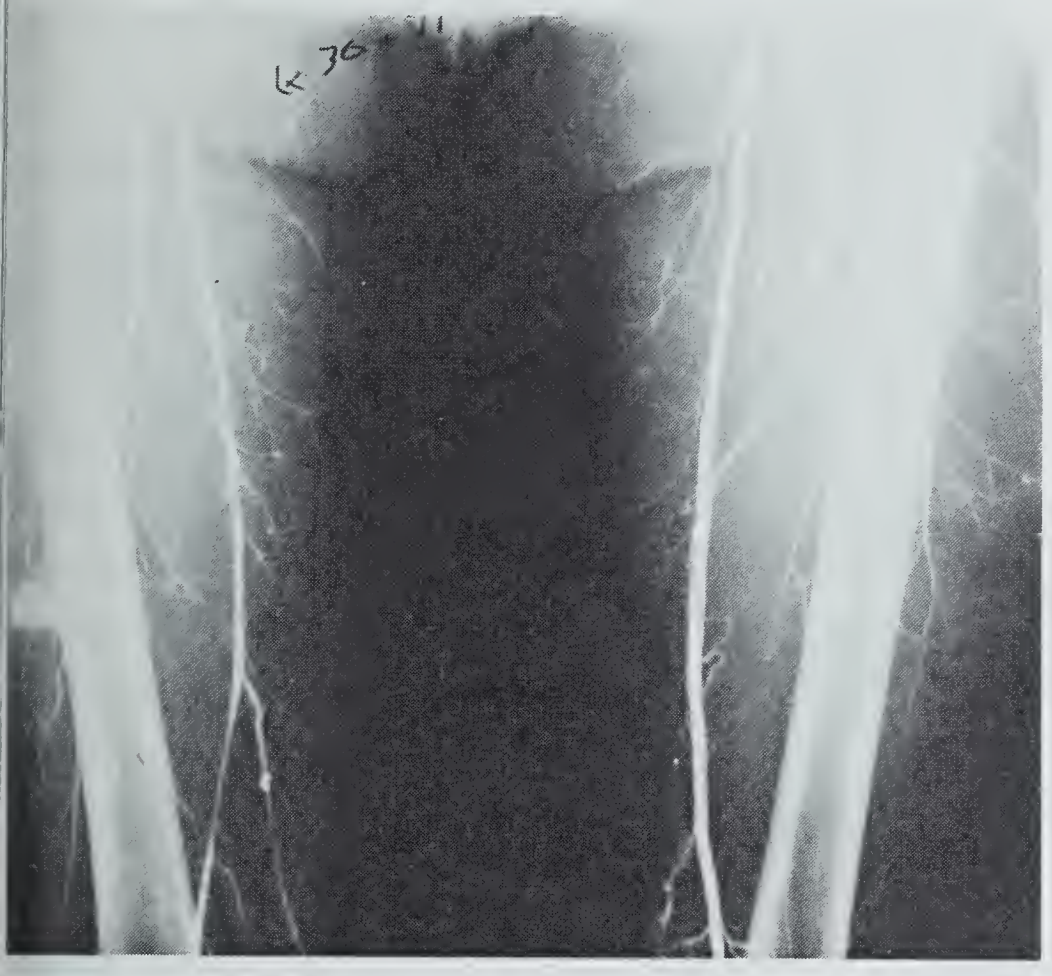


Figure 2. Arteriogram — spasm superficial right femoral artery.

the end of the five days the ankle systolic pressure was the same as the arm pressure. A repeat angiogram was performed on the eighth day at which time external iliac and femoral arteries had returned to normal caliber. The patient was dischaged on the ninth day after admission.

Discussion

On review of literature it is found that most of the patients are young and women predominate, reflecting higher incidence of migraine in woman. The actual incidence has estimated to be less than 0.014 of patients taking Ergot preparations.

Ergot is a product of a fungus, claviceps purpura, that grows on rye and other grains, rye being the most susceptible. Ergotamine Tartrate is presently available in a wide variety of compounds for the treatment of recurrent headaches. There are three major side-effects: (1) Neurologic: headache, vertigo, psychosis, convulsion and coma. (2) Alimentary: diarrhea, cramping, abdominal pain, nausea and vomiting, and (3) Vascular.

The most important side-effect is intense vasospasm which predominates at small doses and due to direct stimulation of the alpha receptors in the vessel wall. The vasospasm can virtually affect any vessel including the coronary arteries and splanchnic circulation.[2, 5, 6] Peripheral alpha adrenergic blockage[19] is seen in doses much higher than those used therapeutically. Besides intense vasoconstriction there is also toxic damage to the capillary endothelium with loss of plasma into the perivascular tissue and is felt to be due to occlusion of the vasa vasorum and necrosis of vessel wall can occur, if prolonged above change may cause stasis thrombosis and gangrene.

Generally three patterns of toxicity are seen: (1) Acute reaction following short term use of the drug in small doses. (2) Intoxication due to excessive large dosage given acutely. (3) Where therapeutic doses have been given for a long time with symptoms appearing late in the course of the therapy.[4, 8, 10, 14, 18, 21, 25]

Clinical manifestations of Ergot poisoning are well known. They may appear at any time during the therapy. Some time the patient may use Cafergot as an analgesic for the body pain other than migraine. The skin may be cold and numb and the peripheral pulses may be difficult to feel or be absent. Blisters may form and frank dry gangrene may set in if no medical help is sought. The patient may also complain of severe burning in an involved extremity, so-called ''Saint Anthony's Fire.'' It is hard to differentiate from severe atherosclerotic vascular occlusive disease unless proper history is obtained.

Arteriographic findings are typical. There is generalized symmetrical narrowing [13, 25] but segmental narrowing has also been reported.[1] When renal involvement occurs it may look like changes of fibromuscular dysplasia. With local occlusion or diffuse spasm, the collateral vessels become prominent. These changes disappear when medication has been stopped and repeat angiogram has confirmed this in many cases. Thrombosis may occur if the initial damage has occurred.

Treatment is entirely expectant and the patient improves within a few days as the drug is metabolized. When patients are seen in advanced state and limb loss is imminent, various pharmacological agents have been used to achieve vasodilation. These include Ethyl-alcohol, Amyl Nitrate, Scopolamine, Phenotolamine, Nicotinate, Papaverine, Procaine, Lidocaine and Tolazoline. Of these Nicotinate, and Tolazoline may be of some benefit.[22, 23, 25] The use of low molecular Dextran[7, 16] and Heparin[11] seems logical in view of developing stasis and thrombosis due to vasospasm.

It is difficult to obtain vasodilation by using vasodilator as Ergotamine is tightly bound to the alpha receptors. It is well known that Ergotamine is pure vasoconstructor in sympathectomized limbs.

Summary

Serious vascular complications can occur in patients taking Ergotamine for migraines. Proper history should always be obtained. Arteriographic findings are very typical in patients taking Ergotamine; simple treatment should be discontinuation of the medication. If tissue loss is impending, Heparin, Dextran and intra-arterial Tolazoline or intravenous Nicotinate should be tried. If

no response to above, sympathetic block should be attempted even though there is no evidence that it will help. I recommend that surgery on blood vesels should be deferred.

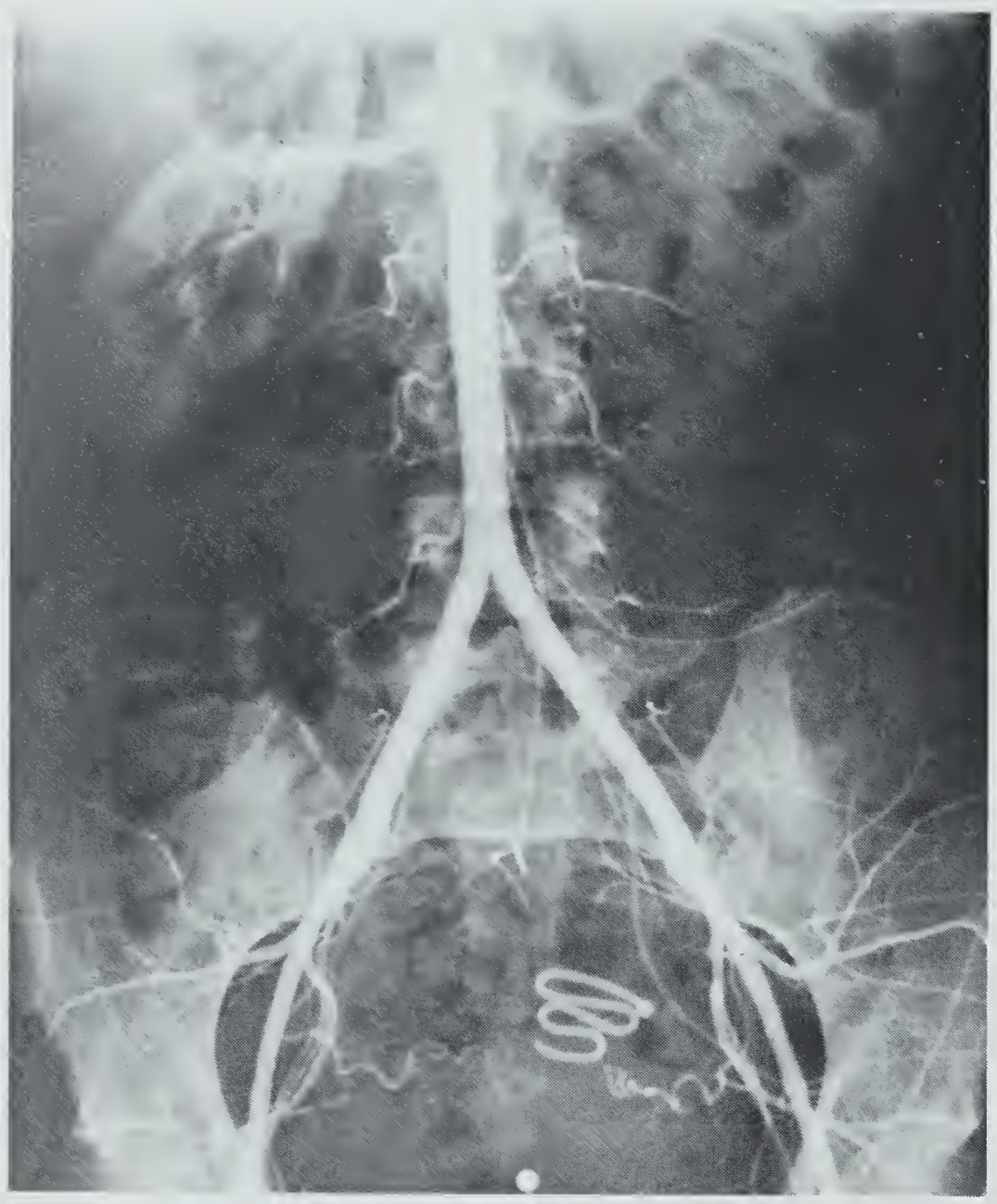


Figure 3. Aortogram — normal right external iliac artery 8 days after withdrawal of Cafergot.

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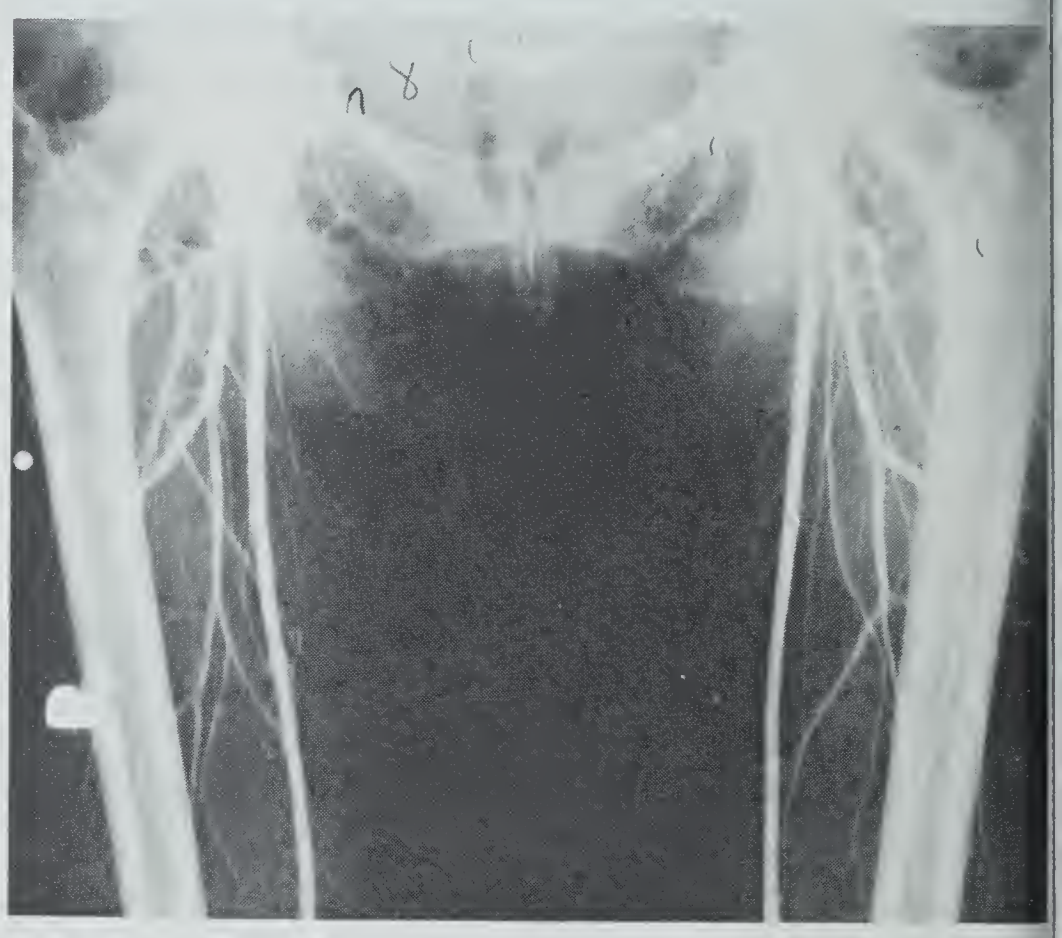

Figure 4. Arteriogram — normal superficial femoral artery 8 days after withdrawal of Cafergot.

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Clinical Notes on His Excellency, James Elisha "Big Jim" Folsom — Governor of Alabama (1947-1951 and 1955-1959)

John T. Morris, M.D.

The voice on the telephone said: "This is Jamelle Folsom and Big Jim is having a bad attack. Would you please come to see him?"

I would indeed!

The mid-twentieth century spawned a group of colorful southern governors, among them Huey P. Long of Louisiana, Theodore Gilmore Bilbo of Mississippi, Herman Talmadge of Georgia, and Strom Thurmond of South Carolina, but the most flamboyant of all was James Elisha "Big Jim" Folsom of Alabama.

His rise to power had been meteoric. He had shown himself to be a brilliant and tireless campaigner and had won his second gubernatorial election by a landslide vote. This was in 1954. In 1962 Mr. Folsom appeared in a television production in which he came off very poorly. He looked sick to me. He lost the confidence of the electorate and lost his election that year by a wide margin. He never did anything half way. For sixteen years Big Jim Folsom had been the most brilliant political figure in the South.

As I hurried to his home on August 9, 1964 there were many questions running through my mind, the main question being: What had happened to this very popular figure to have brought about his decline?

As I entered his bedroom on the second floor of his home in Cullman, I saw that, true to form, Mr. Folsom was not having a small attack, but indeed, he was in the throes of a furious, grand mal seizure. The six-foot nine inch colossus was lying on the floor. His skin was livid. His eyes were dead set. The nostrils were flared. Foamy saliva was flowing from his mouth. He was jerking and drawing. He was breathing very stertoriously. All of his many assembled friends were certain that he was dying.

With the help of six or eight men, we were able to give him a large dose of Sodium Amytal. It required 500mg IV to quiet him sufficiently to move him by ambulance to the Cullman Hospital.

Mr. Folsom's family history was fairly well known. His father was Joshua Marion Folsom and his mother was Eulalah Cornelia (Donovant) Folsom. All of his family had been large people. Most of them were over six feet tall. There was no family history of epilepsy or brain tumors and no seizures of any kind. His past medical history had been mostly uneventful. He had never had any seizures before. He had never even fainted. He had quit smoking cigarettes in the 1940's and had not used any tobacco, in any form, since that time. He was known to be a social drinker and to him that meant a quart or so at a time. He had gone for long periods of time totally abstinent. He had been drinking more alcoholic beverages for the past two years and he had had some noticeable lapses of memory and upon

Credit for typing and editing to Cindy Henry and Miriam Morris.

Compared to amoxicillin

Faster peak. Fewer problems.

. . . in infants and children

Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).[1]

Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.[2]

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.[2]

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.
†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.
2. Multicenter trials. Data to be published.

See important information on page after next.

Compared to ampicillin

Faster peak. Fewer problems.

. . . in adults and children

Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.[3]

Cyclapen®-W is just as effective in otitis media, bronchitis, pneumonia, urinary tract infections and infections of skin and skin structures†.[3]

Cyclapen®-W produces a significantly lower incidence of diarrhea and skin rash.[3]

CYCLAPEN®-W

(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

3. Data on file. Wyeth Laboratories.

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See important information on adjoining page.

Wyeth Laboratories
Philadelphia, Pa. 19101

Cyclapen®-W (cyclacillin)

Indications
Cyclacillin has less in vitra activity than ather drugs in the ampicillin class and its use shauld be confined ta these indications: Treatment of the following infections:

RESPIRATORY TRACT
- Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
- Branchitis and pneumanio coused by *S. pneumoniae* (formerly *D. pneumaniae*)
- Otitis media caused by *S. pneumaniae* (formerly *D. pneumaniae*) ond *H. influenzae*
- Acute exocerbotion of chranic bronchitis coused by *H. influenzae**
- *Though clinical improvement hos been shown, bocterialogic cures connot be expected in oll potients with chronic respiratary diseose due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentory) infections caused by Graup A beto-hemalytic streptococci ond staphylococci, nonpenicillinose praducers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in ony *E. cali* and *P. mirabilis* infections ather than urinary tract.)

NOTE: Perfarm cultures ond susceptibility tests initially and during treotment ta monitor effectiveness of theropy and susceptibility of bocteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Controindicated in individuals with history of on allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Pralonged use of antibiotics moy promate overgrowth of nonsusceptible organisms. If superinfectian occurs, toke opprapriate measures.

PREGNANCY: Pregnoncy Categery B. Reproduction studies perfarmed in mice ond rats at doses up to 10 times the human dose reveoled na evidence of impaired fertility or horm ta the fetus due to cyclacillin. There ore, however, no odequote and well-controlled studies in pregnant women. Becouse animal reproduction studies ore not always predictive of humon response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not knawn whether this drug is excreted in humon milk. Because mony drugs ore, exercise caution when cyclacillin is given to a nursing womon.

Adverse Reactions Orol cyclacillin is generolly well taleroted. As with other penicillins, untoword sensitivity reactians are likely, porticularly in thase who previously demanstrated penicillin hypersensitivity or with histary of allergy, osthma, hay fever, or urticario. Adverse reactions reported with cyclacillin: diorrheo (in opproximotely 1 out af 20 potients treated), nausea ond vomiting (in approximotely 1 in 50), and skin rosh (in approximately 1 in 60). Isolated instonces of headoche, dizziness, obdominal poin, voginitis, ond urticaria have been reported. (See WARNINGS) Other less frequent adverse reoctions which moy occur ond are reported with ather penicillins ore anemio, thrombocytopenia, thrombocytapenic purpuro, leukapenia, neutropenia ond eosinophilio. These reactions ore usuolly reversible on discontinuation af theropy.

As with ather semisynthetic penicillins, SGOT elevotions hove been reported.

As with antibiotic therapy generolly, continue treotment ot least 48 to 72 hours ofter potient becomes osymptomatic ar until bacterial eradicotian is evidenced. In Group A beta-hemolytic streptococcal infections, ot least 10 doys' treatment is recammended to guard ogoinst risk of rheumatic fever or glamerulonephritis. In chronic urinary tract infection, frequent bacterialagic and clinicol appraisal is necessory during therapy and passibly for several manths after. Persistent infection moy require treotment for several weeks.

Cyclocillin is not indicoted in children under 2 months of oge.

Patients with Renal Failure Cyclacillin moy be safely administered to potients with reduced renal function. Due to prolonged serum half-life, potients with various degrees of renol impoirment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spoced doses)

INFECTION	ADULTS	CHILDREN*
Respiratary Tract		
Tonsillitis & Phoryngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonio		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/doy q.i.d.
Chranic Infectians	500 mg q.i.d.	100 mg/kg/doy q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg ta 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosoge should nat result in o dase higher thon that for odults.
†depending on severity

How Supplied Tablets 250 mg ond 500 mg in battles of 100. Oral Suspension 125 mg ond 250 mg per 5 ml in battles ta make 100 ml and 200 ml of Suspension.

Wyeth Laboratories
Philadelphia, Pa 19101

some occasions, had not been quite himself. He had been unhappy and despondent over losing the last gubernatorial election, but was confident that he could win the next one. During the hot weather, he had been consuming large quantities of gin and tonic. Just before the present attack, the patient had been eating some boiled peanuts and appeared to be fairly normal.

Physical Examination

The patient was a large man. No serious physical abnormalities could be detected. There were no stigmata of Marfan's Syndrome or hyperpituitarism. His heart and lungs were normal. There were no murmurs and no splitting of the sounds. The patient weighed approximately 280 pounds. After he recovered from his seizure the neurological examination was completely negative. His fasting blood sugar was very slightly elevated. The electrocardiogram was normal except for slightly prolonged PR interval to .24 seconds. He had mild hypertension. We were at a loss to explain the grand mal seizure.

The patient was referred then to the University of Alabama Hospital in Birmingham under the care of Dr. Joseph Reeves. Dr. Reeves noted mild abnormalities of liver function and slight elevation of bilirubin and SGOT of 85. Glucose Tolerance Test was within the normal range. The patient was examined by a neurologist and his findings were normal. Electroencephalogram was reported as normal. The patient was discharged on a dietary regimen and was advised to increase his exercise program and to restrict alcohol consumption. He was discharged from the University Hospital on August 24, 1964.

On October 20, 1964 the patient was readmitted to the University Hospital. He had had another grand mal convulsive seizure. On this occasion, he had progressive aphasia, but there were no other localizing neurological signs. At this time, the brain scan was negative. The patient was seen by Dr. Garber Galbraith on the neurosurgery service. Carotid arteriograms revealed a space-occupying lesion in the left parietal lobe.

I visited with Mr. Folsom after he had been told of these findings and he was, naturally, quite upset. However, he did want to live and he wanted to be able to impart information to his children who were growing up and showing an interest in politics. He had recovered his speech at this time and he looked me squarely in the eye and said, "You be here at the operation and if it is malignant and it is going to prevent my functioning normally, you see that I do not leave the operating room alive."

Of course, this was an order that I could not, under any circumstances, carry out, so I lied to him for the first and only time during our long association. I looked him squarely back in the eyes and said, "Governor, you do not have a tumor. You have a subdural hemato-

ma and this operation is going to cure it and that's all there is to it.'' This seemed to allay his anxiety and he went very cheerfully into the surgery. I then had an opportunity to talk to Dr. Galbraith and he told me that his feeling was that this was a tumor. The operation went very smoothly. A very large intracerebral hematoma was evacuated and a few adjacent fragments of brain were sent to the laboratory. All were reported benign. The patient recovered in a routine manner. When he was told that he had been having Jacksonian seizures, he replied, ''That figures. I've always been a Jacksonian Democrat.''

Mr. Folsom did very well following this operation. He made an unsuccessful campaign for governor in 1966. Following this defeat, he spent a little time in Hot Springs, Arkansas and imbibed much alcohol. He was brought back to the Cullman Hospital Emergency Room with a very severe grand mal seizure. Once again, he responded to intravenous Sodium Amytal and intravenous Dilatin Sodium. After four days he was transferred to the University Hospital for further evaluation. He was put on an anticonvulsive program at this time, with fairly large doses of Dílantin Sodium and Phenobarbital. He was urged to refrain from any alcohloic beverages. I feel certain that he has not imbibed any alcoholic beverages since that time.

On May 16, 1966 the patient was readmitted to the Cullman Hospital, after an automobile accident, with a fracture of the right clavicle, fracture of the fourth rib on the right, and a fracture of the hand. He recovered quickly and was discharged after five days in the hospital.

He did very well for the next four years, apparently, but on December 1, 1970 the patient came into my office very short of breath and with severe hemoptysis. This had been going on for approximately one week. He had been to the Flint Tuberculosis Sanitorium near Decatur where the tuberculologist had examined him thoroughly and said that he did not have tuberculosis. He told him to see his family physician. Upon this recommendation, he had come to me. I hospitalized him in Cullman Hospital.

Physical Examination on December 1, 1970

The patient is breathing stertorously. There are audible wheezes without the stethoscope. He is very short of breath, coughing up some blood-tinged, foamy sputum.

HEAD: Hair pattern is normal. There is a defect in the parietal area of the skull where a craniotomy has been performed, previously.

Ears: Pinnae, E.A.C, and drums are normal.

Eyes: Conjunctivae are slightly injected. Media are clear except for the left lens which is opaque. Pupils react to light and upon accommodation.

Nose: Nasal mucus membranes are slightly in jected, but nares are patent.

Mouth: The posterior pharynx is normal. Tongu shows no papillary atrophy. Protrudes in th midline with no fasciculation or deviation.

Neck: Supple. Trachea is in the midline with n tug. Carotids pulsate equally bilaterally. Ther is pronounced jugular distention.

CHEST: The patient is a large man. The chest is sym metrical. Breathing is very loud and there are sibilar and sonorous rales throughout both lung fields Some tracheobronchial rales are present, but mostl the lungs are completely wet, anteriorly and pos teriorly. The heart does not appear to be enlarged t inspection. The PMI is difficult to find, but appear to be approximately at the left, mid clavicular line a the level of the left 6th interspace. The heart sound are completely obscurred by the stertorious breath ing.

ABDOMEN: The liver is three to four finger breadth below the right, costal border and this is new. It wa not that way on his previous admissions. No othe organs, masses, or herniae are palpated.

GENITO-URINARY SYSTEM: Negative externally

NEURO-MUSCULAR: Negative. DTRS are norma and equally bilaterally. Kernig, Romberg, an Babinski are negative. No sensory deficits.

SKIN: Slightly cyanotic and moist.

The chest x-ray showed what appeared to be multipl tumors, bilaterally, but proved to be pseudotumors du to the pulmonary edema. EKG was reported as un changed from previous tracing. CPK and SGOT wer normal, but the LDH was elevated to 320, 380, and 44 on serial determinations. The electrolytes and BU were normal. After the patient had been digitalized an diuresed, the lung sounds were improved, and on could hear a very loud, holosystolic cardiac murmur He was transferred to the University Hospital wher further studies were made. Transurethral prostatec tomy was performed by Dr. Sheridan Shirley upon th recommendation of Dr. Joseph Reeves, in preparatio for cardiovascular surgery.

He was then allowed to make a ''hand-shaking'' tri to south Alabama. He returned to the University o February 23, 1971. At this time, a Starr-Edwards mitra prosthesis was inserted by Dr. John W. Kirklin t replace the mitral valve because of rupture cordae tindi nae of the posterior mitral valve leaflet. The patient ha been on Dilantin Sodium and Coumadin since tha time. He also was on Pronestyl and Diuril for a shor time, but these have been discontinued.

While Mr. Folsom was in the hospital for his car diovascular surgery, he was cheerful and happy. He di not complain of the post-operative pain. He visited wit the other patients and was a source of inspiration t

iem. He met the actor, Milburn Stone, who had por-ayed ''old Doc'' on Gunsmoke and they became fast iends. Milburn Stone's surgery was also done by Dr. irklin. Mr. Folsom was very unhappy that this actor's ost-operative course had not been very good. Of ourse, he did recover eventually and live for quite a hile after his surgery. He and Mr. Folsom remained iends.

In April of 1971 the patient was admitted to the ntensive Care Unit of the Cullman Hospital. He had ad an episode of aphasia followed by echolalia. He ad lost consciousness and had had another grand mal eizure. Once again, he was treated with Sodium mytal and he responded very quickly. Since he had ad the previous brain surgery at the University Hospi-l, he was referred back there for evaluation. He re-ained there for two weeks, and during that time, he as treated for viral bronchitis.

The years from April of 1971 to March of 1975 were ood years for the former governor, but early in March f 1975, he began having severe left-sided headaches nd pain in the left eye. The pain increased in severity o the point that he did not sleep for two nights. On the hirteenth of March he was seen by Dr. Garber Gal-raith, who got ophthalmological consultation by Dr. Vatanabe. The patient had been seen from time to time y ophthalmologists. He was known to have a cataract f the left eye, but had been advised against surgery ecause the right eye's vision was so good. However, n this occasion Mr. Folsom was found to have severe laucoma of the left eye and was treated very sten-ously with intravenous Mannitol. Glycerin drops to he surface of the left cornea had revealed a completely losed, anterior chamber angle. He was treated with ilocarpine installation, Diamox intravenously, retro-ulbar anesthesia with 2% xylocaine and epinephrine, nd massage of the globe for thirty minutes. After these reatments, the intraocular pressure came down some-vhat and Mr. Folsom was able to sleep. He then had a emoval of the cateractous lens. Following this, he ontinued to be plagued by poor vision and various eurological problems.

On July 22 he was readmitted to the University Hospital because of mental confusion which had lasted or four days. At that time he was on Diamox, Dilantin, Pronestyl, Coumadin,and Phenobarbital. During that dmission, the patient had many seizures. He also had pisodes of ventricular premature beats with bigeminy nd trigeminy. His vision in the right eye began to fail omewhat. In August the patient had central, retinal rterial and venous occlusion of the right eye and old etinal hemorrhages of the left eye.

In April of 1977 Mr. Folsom had an episode of lobar neumonia of the right lower lobe and, concurrently, leeding hemorrhoids. He was on anticoagulants. Fol-owing the pneumonia he developed a toxic dementia nd toxic delirium. Upon this occasion his anticonvul-sive drugs, including his Dilantin, had to be readjusted. His anticoagulants had to be readjusted, but, all in all, the patient recovered satisfactorily, and by May 6, 1977 was in fairly good form again. His main complaints, at this time, were his blindness and impotence due to the prostatectomy.

In October of 1980 the patient once again had an acute episode of bronchopneumonia with acute congestive heart failure. This had been complicate by some ventricular premature beats which were felt to be right ventricular in origin and not very serious.

At the time of this writing, Mr. Folsom is in very good health. He has very little cardiac congestion. He has had no seizures for approximately one year. He has been on anticonvulsive therapy for seventeen years. He has been on anticoagulants for ten years. He is now totally blind, but his main complaint is impotence. He is considering surgical correction for this.

Conclusion

From the nineteen forties to 1962 James Elisha ''Big Jim'' Folsom was the most popular political figure in the South. It was felt that he would certainly win the election of 1962. Shortly before the election Mr. Folsom appeared on a television program. He appeared sick to some people. He appeared intoxicated to some people. He appeared doped to some people. He appeared to be incompetent to nearly all of the voters, and instead of winning by a landslide as had been predicted, he received his worst political defeat. He moped, was depressed, and drank heavily until August 9, 1964, at which time he had a grand mal seizure and an intracerebral hematoma was removed. It is my opinion that this brain lesion was the cause of Mr. Folsom's behavior on the night preceding the election of 1962. Jacksonian seizures, notoriously, come late following cerebral damage and/or scar tissue formation.

Just prior to the neurosurgical operation for the removal of the hematoma, Mr. Folsom showed his only signs of defeatism. Since that time, his entire philosophy has been ''onward and upward. Let's get the job done, whatever it is.'' He has shown a remarkable tolerance and affection for people and disregard for the pain that he himself has experienced from median sternotomy of the cardiovascular surgery, craniotomy, and other surgery. He has not complained of his blindness. He is totally liberated from alcoholism. He has no stigmata of alcoholism, no cirrhosis, and no alcoholic encephalopathy. He has never had any venereal disease and certainly has never had any positive serology. He has had no congenital disease such as Marfan's Syndrome or pituitary gigantism. Mr. Folsom is a normal, very big person. His career in politics has been legendary and his era is now regarded as ''the good ole days.''

continued on page 46

DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo–

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**

As seen on admission

After one week of penicillin V-K therapy

Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth All 14 healed, regardless of which antibiotic was administered.	(14 patients)	9	5
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus,* 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes,* and 1% beta-hemolytic *Streptococcus*.‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

BRISTOL®
Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

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PHYSICIANS: TRY AIR FORCE EXPERIENCE.

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Phone: (205) 279-4006 collect.

R

Happy New Year

Mrs. Rufus E. Lee, Jr.
President, A-MASA

I like the dreams of the future better than the history of the past.
—THOMAS JEFFERSON

The first of every year we all begin making New Year's resolutions. Even though we know most of them will be forgotten by the end of January, it's still a great time to reevaluate last years goals and outline plans for the future. As time passes and situations change, we must adjust or delete old goals and add new ones.

This year I'm going to try to be more realistic with my resolutions. From past experience, I know my house cleaning will not improve nor will I have a hot meal on the table every night, so those two are being dropped from my list. Still I must keep the one about losing 10 pounds because there's always hope that someone will discover a delicious chocolate fudge with no calories.

The Auxiliary is always a top priority! Let's see now. What do we need to accomplish in 1982?

1. — Continue to Assist the Medical Association with the Impaired Physician Rehabilitation Program.
2. — Promote Organ Donor Program.
3. — Promote Child Safety Through Infant Seats and Child Restraits.
4. — Radio Interviews to Educate Public on Better Health & Produce a Good Public Image for the Physician.
5. — Support the Resident Physicians Medical Student Spouse Program.
6. — Assist in Child Abuse Programs.
7. — Participate in Programs for the Aging.
8. — Stress & Worry Clinics.
9. — Projects to Support AMA-ERF (We donated $1.6 million nationally last year).
10. — Use Our Talents Wherever Needed to Assist in Health Education.
11. — Support Good Medical Legislation.
12. — Increase Membership.

Membership is vital to the life of any organization and especially to the Medical Auxiliary. What can I say that hasn't been said many times before to encourage new members to join? Surely every physician's spouse wants to be part of an organization that has as its primary objective "to improve the health and welfare of the people in their community."

Many people think of the doctor's wife as one who goes to teas, luncheons, fashion shows and wine parties. Yes, we do those things and they are done for several reasons — to communicate among ourselves about advantages and problems of belonging to a medical family — to simply socialize and get to know and care for each other — *and to raise money for AMA-ERF* or other health-related projects.

Your spouse is definitely needed to contribute her time and talents to help with fund raising projects, to nurture good attitudes about the medical profession and to extend your abilities to provide better health care.

If by chance she cannot participate due to illness, working or caring for small children we still value her membership. We need her moral support and her dues to help educate our leaders at workshops, to pay for printing *Facet* magazine, *Horizons* newsletter, and many other publications.

Please help us to help you! Encourage your spouse to join us early in 1982.

Imagine what the combined efforts of all the physicians and their spouses can do to improve the quality of life in Alabama in one year!

You cannot climb the ladder of success
with your hands in your pockets.
—ANONYMOUS

MASA + AMASA = DYNAMITE

MARY JULIA LEE

Mary Julia Lee

"Big Jim"

continued from page 41

I hereby give full consent and permission to Doctor John T. Morris and the JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA to publish any and all clinical materials available to them regarding myself including information acquired in the course of my examination and treatment and also including any medical history.

This form has been read to me and I am fully comprehend its content in its entirety.

JAMES ELISHA FOLSOM
JOHN T. MORRIS, M.D.
DORIS SCOTT, Witness

Dated at Cullman, Alabama, this 22nd day of September 1981.

I have read the consent form signed by my husban James Elisha Folsom, and hereby give my permissi to Doctor John T. Morris and the JOURNAL OF TH MEDICAL ASSOCIATION OF THE STATE OF ALABAMA, publish any and all clinical materials available to the regarding the treatment of Mr. Folsom including i formation acquired in the course of his examination ar treatment and also including any medical history.

MRS. JAMES ELISHA FOLSOM
JOHN T. MORRIS, M.D.
DORIS SCOTT, Witness

Dated at Cullman, Alabama, this 22nd day o September 1981.

Photo/David Fullard

"I'm a professional dancer, actor and storyteller who just happens to be dea

These are the words of a very spirited man who has pushed and pushed hard to obtain his goals.

Born deaf, his greatest joy while growing up was watching the famous Hollywood musicals choreographed b Busby Berkeley on TV. As a child, he recognized his overwhelming response to music and dance. "I didn't have hear the music because the music was inside my body. I fe proud and beautiful when I dance."

His interest in dance, theatre and storytelling began during his early school years and continued through colleg to the present time.

As for most schools for the deaf, Sam Edwards states emphatically, "Hearing Authorities refuse to listen to deaf people's opinions. They are deaf and blind. They want deaf people to talk, to wear hearing aids and to be like hearing people. Many deaf people including myself are left with ba scars because of our experiences at school."

One of the points that Sam Edwards stresses is that there is already too much violence in the world and he does believe in being violent or militant on his behalf or for deaf people as a group.

So Sam Edwards' militancy takes the form of encourag other deaf people to pursue all art forms as a means to express their creativity and to gain exposure anywhere and everywhere possible. In fact, he wants deaf people to becor the visible as opposed to the invisible minority.

President's Committee on
Employment of the Handicapped
Washington, D.C. 20210
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Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General*: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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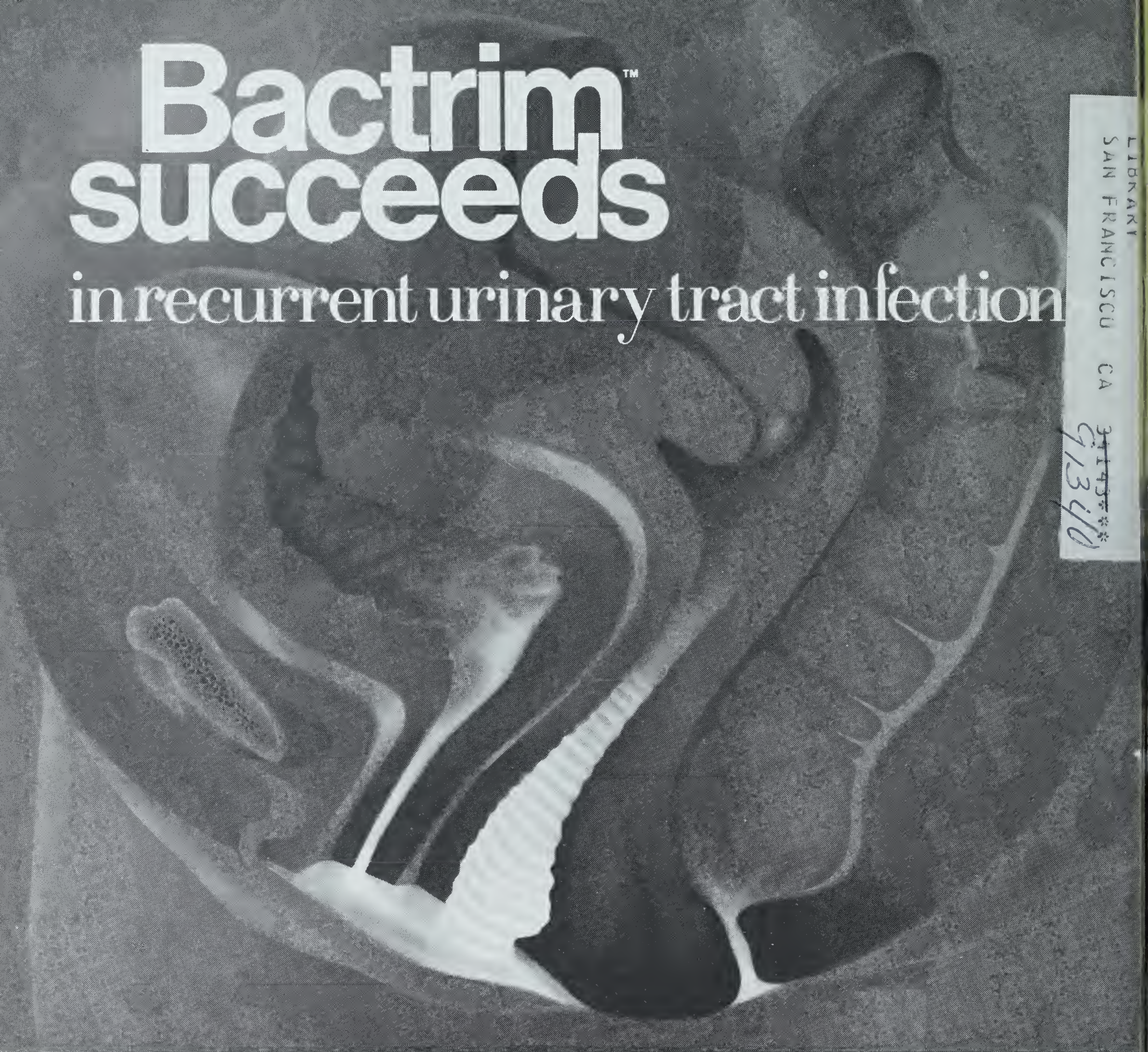
Bactrim™ succeeds

in recurrent urinary tract infection



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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1] . . . the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1] . . . and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980. **2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS

160 mg trimethoprim and 800 mg sulfamethoxazole

DOUBLE STRENGTH TABLETS

maximizes results with B.I.D. convenience

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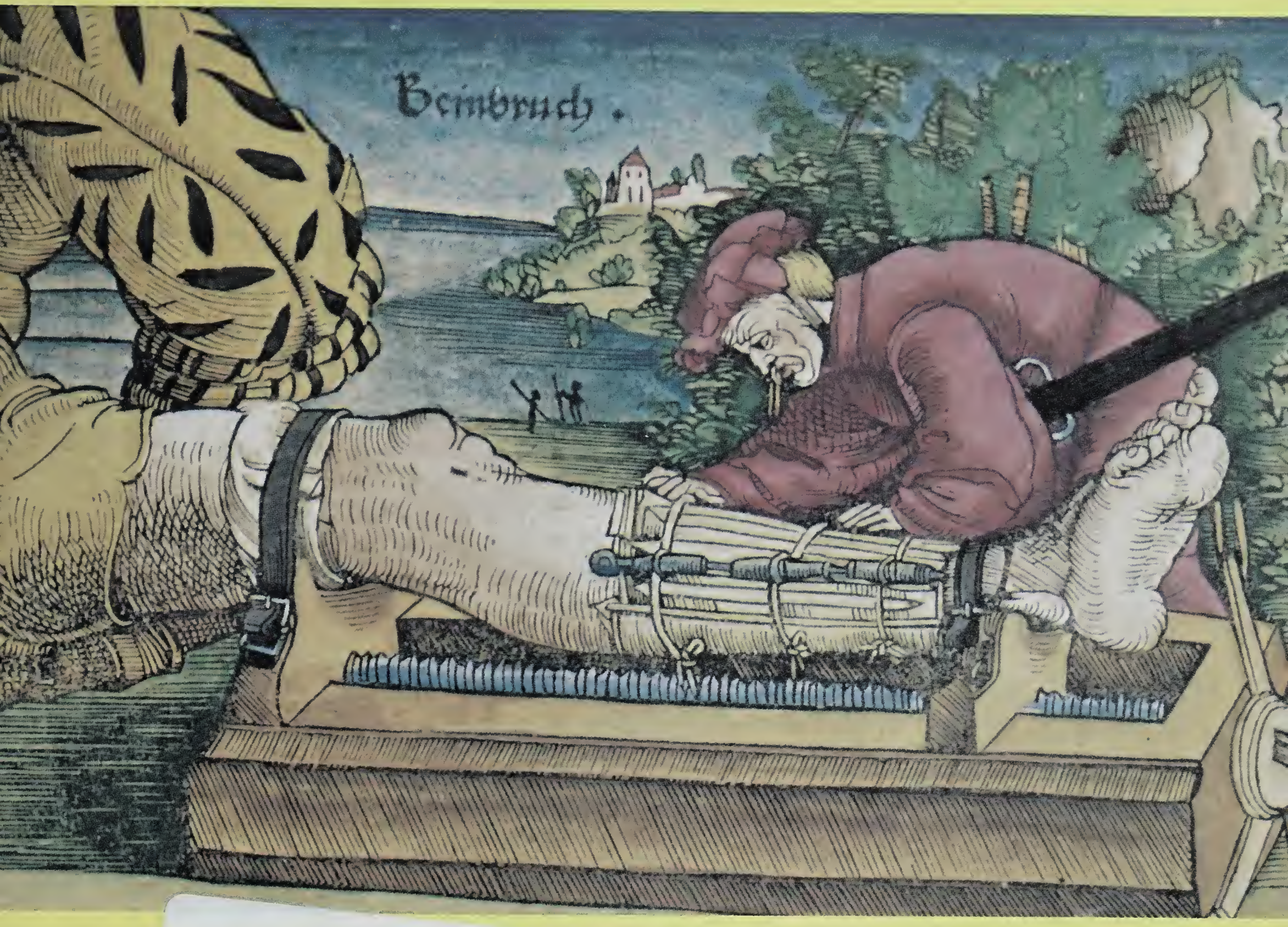
*due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

JOURNAL

of the Medical Association of the State of Alabama

VOL. 51, NO. 8, FEBRUARY, 1982



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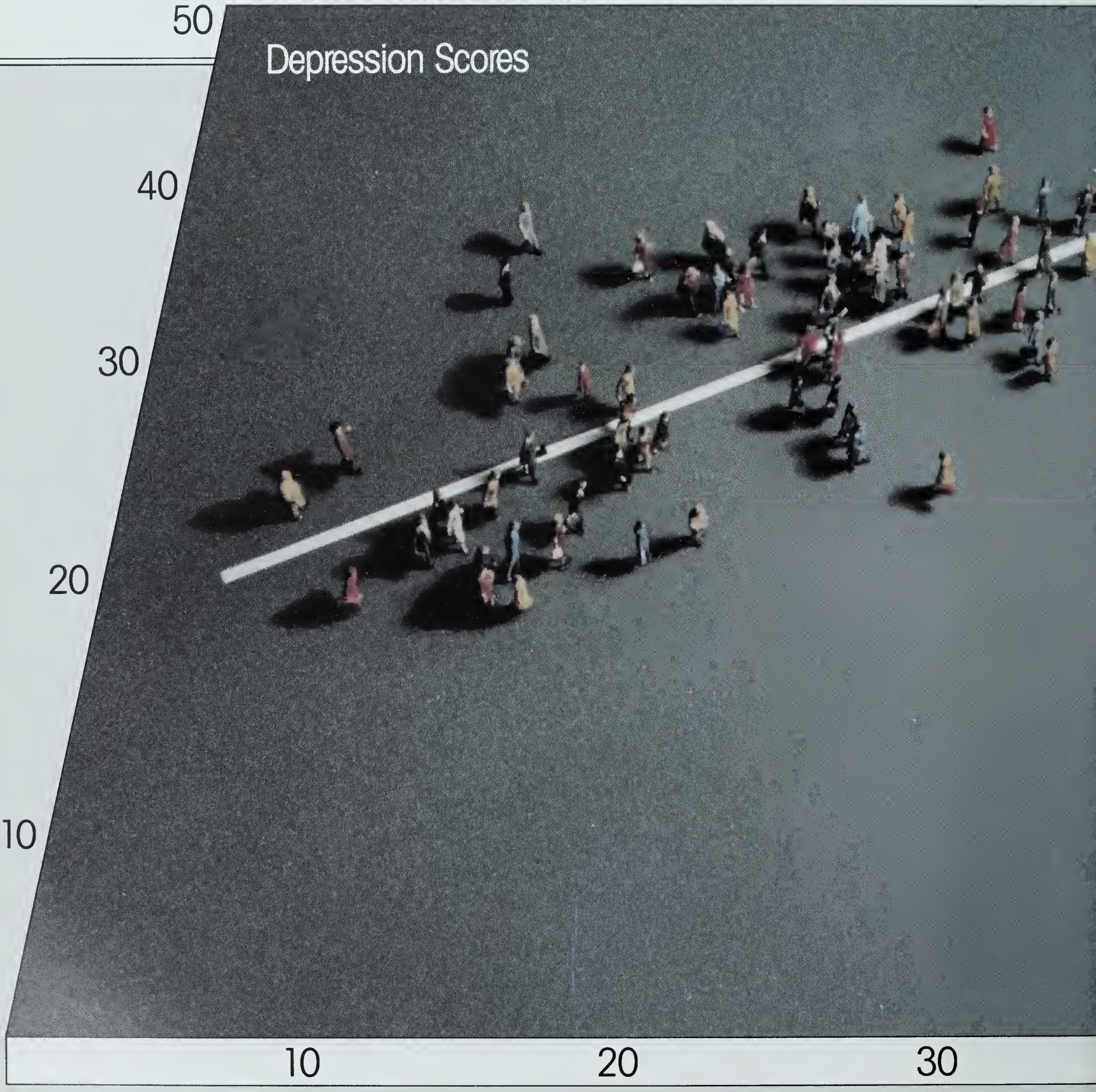
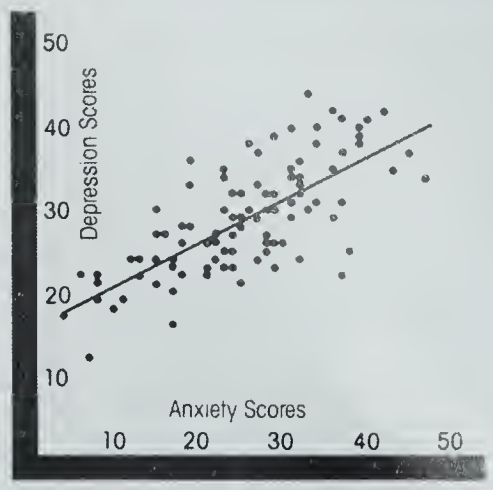
FOR THE 7 OF 10 NONPSYCHOTI





Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3]Adapted from Claghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]

Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine,* ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Claghorn J: The anxiety-depression syndrome. *Psychosomatics 11*:438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61*:217-225, 1979.

In moderate depression and anxiety

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Relief without a phenothiazine

Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12.
In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

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The *Stylebook/Editorial Manual,* published by th AMA, is the general reference for questions of style. is particularly useful in the proper presentation of data Available at cost ($6.50) from MASA. When conflic occur between usage, etc., by an author and th stylebook, these will be resolved in favor of the autho if his method is persuasive and logical.

Helpful to many writers is *The Elements of Style* b William Strunk Jr. and E. B. White, which emphasize brevity, vigor and clarity. Available at cost ($1.6 from MASA.

Final authority on grammar is Webster's *New Interna tional,* Unabridged, Second Edition.

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On the Cover

During the Middle Ages, and even much later, medical models of exaggerated sizes were often used to demonstrate technique.

This month's cover, from a 15th Century woodcut in the Reynolds Historical Library, UAB, uses a giant's leg to demonstrate an orthopedic procedure, presumably reduction of a fraction. Copy by MASA from the Reynolds collection.

EXECUTIVE DIRECTOR

Adding Insult to Injury

In the years I have been Executive Director of the Association, I have collected, as I am sure all physicians have, a number of stereotyped grievances by the public against doctors.

Recently, I was surprised to read in *The New York Times Magazine* that Isadore Rosenfeld, M.D., clinical professor of medicine at the New York Hospital-Cornell Medical Center, had encountered almost precisely the same criticisms I have.

Dr. Rosenfeld is author of the best-selling book *Second Opinion*. In the course of the usual promotional tour around the country, submitting to newspaper, radio and television interviews, he found to his great chagrin that few interviewers cared at all about getting healthy and staying healthy, about the new diagnostic techniques, or about the strides being made in medical and surgical treatment.

"I found myself subjected," Dr. Rosenfeld wrote in a stirring defense of his calling, "to a continuing barrage of angry complaints about the medical profession."

Dr. Rosenfeld heard comments most of you have been hearing for years. Examples:

"My doctor's office is an assembly line. . . .

"The personal touch is gone. . . .

"No one listens, communicates or seems to care anymore. . . .

"I am treated not as a person, but as an appendix, a hernia, a heart attack, a hemorrhoid." And so on.

From Atlanta to San Francisco, he said, from Seattle to Houston, such grievances covered a wide spectrum:

"Like most members of my profession I had been going about the daily business of treating the sick, convinced that the public knew that, despite the changes in the form of medical care, its substance has never been better. If doctors no longer sit up all night with their pneumonia patients, that is because they are confident that a few shots of the right antibiotic will insure a speedy recovery. If, after brief examination, they send their patients on to a specialist, that is because the fund of medical knowledge has grown so enormously that no one physician could possibly master it all. Americans are living longer, healthier lives than ever before and most doctors think they are entitled to at least some of the credit. Yet the public's complaints are real and intensely felt. . . ."

It is difficult to convince people that the cost of medical care cannot be insulated from the rest of the economy, he found. People resent deeply the price of being sick, far more deeply than the cost of the "well" necessities of life.

People feel that hospital charges and doctor fees should somehow be exempt from the general effects of an inflated economy. Those who resent the fact that a doctor makes a good living have only admiration for a lawyer or realtor or corporate executive who makes much more. The doctor is profiteering from misfortune, the public seems to be saying, while the executive in business and industry is admired for being a success. Dr. Rosenfeld comments:

". . . In a free society, where the acquisition of wealth is a fairly common goal, should doctors really be judged differently from other professionals?

continued on page 53

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DESCRIPTION

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerotomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets	NDC 0524-0058-01
Bottles of 500 Tablets	NDC 0524-0058-05

Federal law prohibits dispensing without prescription.

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RU-TUSS®
Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 m
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 m
Phenylpropanolamine Hydrochloride	20 m
Pheniramine Maleate	20 m
Pyrilamine Maleate	20 m
Ammonium Chloride	200 m
Alcohol	5

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expe torant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upp respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhi tis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nas congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an ar hypertensive or antidepressant drug containing a monoamine oxidase inhibitor contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma a in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient shou be warned of the potential that this drug may be habit forming Ru-Tuss Expectorant m cause drowsiness. Patients should be warned of the possible additive effect caused taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle operating dangerous machinery (See Warnings). Caution should be taken with patie having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddine dryness of mucous membranes, tightness of the chest, thickening of bronchial secretio urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, fai ness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xer stomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric c tress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessne excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and ev convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoonfuls in c 24-hour period. Children 2 to 6 years of age: ½ teaspoonful every 4 hours, not exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use directed by a physician.

HOW SUPPLIED: (16 fl. oz.)

Pint Bottles	NDC 0524-1010-

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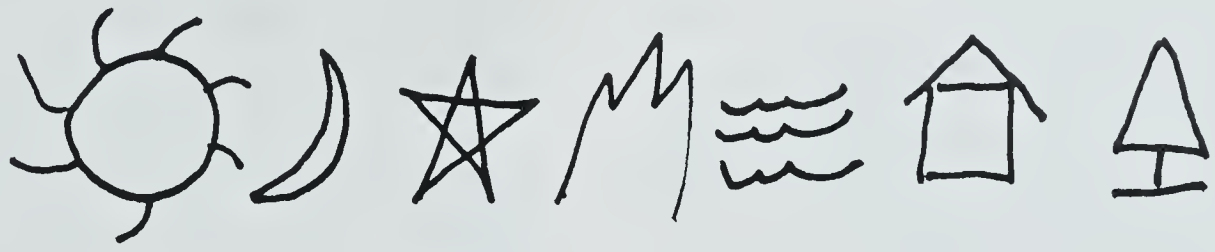
An Imitational Treatment Language

Jack R. Anderson, M.D.
Clinical Professor of Psychiatry
University of Alabama in Birmingham
School of Medicine



This is the third report on the application of selected principles of Jean Piaget's developmental psychology to psychotherapy.[1, 2]

Relevant Piagetian Principles:

. The experience of the human neonate is characterized by pervasive undifferentiation. In this state of awareness there is no discrimination between subject and object, here and there, now and then, cause and effect or right and wrong.[3]

. The capacity to represent events not present in the perceptual field is usually developed between 18 and 24 months of age, during Stage 6 of the Sensory-Motor Period. The first representational system of the developing child consists of interiorized actions which stand for or signify external events by replicating them as condensed and schematic imitations.[3]

. Cognitive activity without exception is motor activity. It begins with overt actions performed by the subject, but even the "abstract operations which characterize logical thought . . . are . . . interiorized actions whose efferent impulses do not develop into external movements." Actions, overt and covert, do not constitute a sensory-motor *substrate* of cognition. They *are* cognition in its entirety.[3]

Suite 520, 1717 Eleventh Avenue South, Birmingham, Alabama 35205.

Time Relationships in Different Modes of Experience

In this writer's opinion, there is a time-relationship difference between the initial infantile state of undifferentiated awareness and ordinary adult experience. The initial experience is lived at the *same instant* it occurs. Our ordinary way of experiencing our living or living our experience is after it occurs, *after* we have cognitively processed it and *represented* it with imitational and arbitrary symbols and systems of symbols. In addition, the initial experience is richer and fuller as in the processing we edit, omit much of importance, add material from other times and places, selectively distort, and categorize all we select as right or wrong.

Adults are occasionally permitted to recapture for fleeting instants the immediate, full experience of initial undifferentiated awareness. Sartre's character Antoine Roquentin in *Nausea*[4] finds the experience at first distressing, but "on the other side of despair" he finds the promise of liberation; O'Neill's Edmund Tyrone in *Long Day's Journey Into Night*[5] describes it as exhilirating and liberating. Both writers try to capture the quality of the initial experience in the arbitrary symbols of everyday words. Joyce, in *Ulysses,*[6] uses a mixture of arbitrary symbols (words) and imitational symbols (truncated words and isolated phonemes with an emphasis on sound) to convey the experience of a

stream of consciousness that varies in level of awareness from initial experience through imitational to arbitrary (verbal) cognitive organization. He devotes 768 pages to describing the experience of three people over a period of 18 hours.

This writer believes Joyce's representation of the adult stream of consciousness with a mixture of arbitrary and imitational symbols is the most nearly authentic of any English author. Most of us devote most of our attention to that portion of our stream of consciousness that is farthest away in time from initial experience — the extensively edited, incomplete, distorted remnant of initial experience that is mediated by arbitrary language. With deliberate effort we can direct our attention to the other elements of our ongoing experience, those less organized non-verbal elements that Joyce represented with imitational symbols.

Implications for Psychotherapy

It is believed that the above-discussed differences in time relationships and completeness among the various cognitive-organizational levels of experience present an opportunity for therapeutic intervention. Through psychoanalysis and related treatment methods patients regularly acquire useful insights into their ongoing experience by looking for genetic factors in their past. Postural introspection was developed for this purpose.[1] Perhaps this is only one side of a two-way street. If we therapists can show our patients how to experience life more immediately and completely, closer in time to the instant it occurs, perhaps we will gain insights that will retrospectively illuminate our past. The development of an imitational treatment language is intended as a step in this direction.

Development of the Imitational Language

"Language" is used here in the general sense of Mates' definition: "Any aggregate of objects which are themselves meaningful or else are such that certain combinations of them are meaningful."[7] The symbols themselves are simplified pictures of a sun, moon, star, mountain, sea, house and tree. They were selected by this writer for no particular reason except that they seemed easy to draw and would be generally recognized. These imitational symbols are associated with messages written in arbitrary symbols — words. The distinction between the imitational quality of pictures and the arbitrary quality of words is perhaps illustrated by pointing out that the picture of the sun is more sun-like in appearance than the written word "sun."

When arbitrary language messages are associated repetitively with the imitational language symbols as described in the following case presentation, it is believed that the written messages are condensed and that the pictures come to "stand for" or represent them in a way quite similar to the patient's original symbolic language of interiorized imitations. Then when the pictures are visualized, the associated messages are comprehended closer in time to the instant of initial experience, more completely, with less distortion and relatively free from the conflict between right and wrong. In such experience concepts show themselves, reveal themselves rather than being understood or explained. The non-verbal insights that develop during even fleeting moments of such experience tend to carry over into subsequent ordinary experience and may retrospectively illuminate the past.

A Brief Case Presentation

A 49-year-old married man was a self-referral. About 6 months previously he had experienced a sudden onset of pain radiating down his left arm together with nausea after a brisk walk of over a mile. At this time he was hospitalized and worked up for myocardial infarction. This diagnosis was ruled out after a few days of observation, monitoring and appropriate laboratory studies. Neurological examination and x-rays of the cervical spine supported a diagnosis of nerve root compression with pain and motor, sensory and reflex changes in the left arm. Despite high levels of analgesics, a cervical collar and three hours daily sitting in a home traction device to "stretch his neck," he continued to experience pain and steadily worsening neurological symptoms in his arm and hand and was unable to function effectively on his job or to pursue his avocation of gardening. A neurosurgical referral had been recommended by his treating physician, but he wanted to try a more conservative therapy before considering surgery. Our therapeutic contract stipulated that the treating physician would maintain primary medical responsibility for this obviously organic neurological condition while the patient and I tried psychotherapy as an adjunctive treatment method.

At the first session a brief history was taken and the patient's current personal relationships with family, friends, fellow workers and supervisors were discussed. He was given a "script" which associated each pictorial symbol of the treatment language with a written relaxation message for a specific body part. The patient was instructed to read the script, preferably but not necessarily aloud, while sitting comfortable in a place relatively free from distractions. He was told to do this once or twice daily as time permitted, adjusting his reading speed so that he would finish the script in about ten minutes. Immediately after each session he was to enter in a pocket calendar the time of day and the amount of time devoted to the script reading. Then he was to carefully copy the treatment language symbols to complete his daily entry.

A week later the patient was seen again for a 45-minute session. His diary in the pocket calendar was reviewed. His experiences reading the script were discussed and the author offered some feedback related to his own script-reading and diarying experiences. We

continued our previous discussion of his symptoms and his interpersonal relationships, focusing on verbal and non-verbal communications. The last ten minutes were spent associating the seven pictures with another set of concepts: ''self''; ''growth''; ''choice''; ''feelings''; ''time''; ''symbols'' and ''communications.'' The patient was instructed to write a few sentences about each of these concepts in the spaces which had been left free on his script after each relaxation message. The content of these messages to himself were to reflect the discussions we had had about the importance of his concepts of self-growth, choice, feelings, time, the symbols of the picture language and his communications with himself and others including sending and receiving, verbally and non-verbally, in arbitrary and imitational languages. These added messages were to be included in his daily script-reading session which was extended to fifteen minutes. In addition to the daily relaxation and communication session, the claimant was encouraged to visualize the symbols frequently during the day, when he happened to think of it, when any symptoms were felt, and in times of interpersonal friction, conflict or dissatisfaction.

This brief visual review was explained to him as an interiorized non-verbal restatement of the relaxation and other messages represented by the seven pictures, a condensed expression of the therapeutic assumptions, axioms and postulates that we had generated for him, stated in a language closer to his primary representational system than verbal language is.

The patient was seen for two more sessions at weekly intervals for further discussion of his script reading, his daily living experiences and his symptoms. After that he was seen twice more at monthly intervals. At the last meeting he was instructed to continue the daily sessions and diary entries for at least 18 months.

His pain and neurological symptoms improved within the first week of treatment. He was able to discontinue the analgesics and return to full work and garden activities within a month. His personal relationships with himself, his family, fellow workers and supervisors improved. A telephone interview 18 months after treatment was started revealed a continuing remission of symptoms. The patient was still practicing the daily relaxation and internal communication sessions and keeping his diary entries current.

Discussion

Persons treated with this method have included sexual offenders, habitual excessive drinkers and patients

Are the results of
$100 million worth of
government-funded research
on hypertension
worth reading about?

with diagnoses including schizophrenias, affective disorders, psychoneuroses, personality disorders, sexual dysfunctions, psychophysiologic disorders and tardive dyskinesias.

The theoretical principles and practical demonstrations of the method have been presented as part of in-service training programs at community mental health centers, an alcoholism treatment center and in psychiatric residency programs over the past six years. The counselors in the alcoholism treatment center used the imitational language to keep their own diaries and practiced their own daily sessions over a period of several months of inservice training. During this time they applied the seven concepts associated with the symbols to daily group therapy sessions with their resident clients. At the end of the training period, as part of a joint report on the training, they wrote "Through our experiences in group over the last few months we have all, staff and clients, grown closer and closer together. There has gradually developed an attitude of acceptance that makes it easier for everyone to trust and share and care and love."[8]

Most of the patients treated improved. Those who continued the diary and daily sessions for at least nine months improved substantially. Most of the patients were seen at weekly intervals for ten or more sessions and thereafter scheduled at two-week or monthly intervals for at least ten more sessions when circumstances permitted. The general pattern of response was an initial period of improvement beginning within the first two to five sessions, a plateau for five to six months, then a steady improvement for the remainder of the first year. Only one patient was treated for as long as three years. The patient described herein is the only one who showed continuing improvement after so few sessions.

Group scripts have been prepared to help cigarette smokers reduce or stop smoking. These attempts were unsuccessful. Individual sessions and individually developed scripts are considered essential to the therapeutic effectiveness of this treatment method.

Therapist Participation

In keeping with the principles upon which this treatment method is based "understanding" gained by reading or talking about the method is not considered sufficient preparation for therapeutic application. The therapist prepares his own script, reads it daily and records it in his own diary. He receives feedback from weekly sessions with a trained therapist. After several months of these *activities* the meaning and intention of the method *reveals* itself, *nonverbally* to the therapist as the picture-language messages are gradually integrated into the covert motors sets of his own idiosyncratic language of internalized imitations. Only then is he prepared to communicate meaningfully with patients about experiences mediated by the imitational treatment language.

Closing Comments

The writer has a clinical rather than a scientific bias and does not pretend to have established the effectiveness of this treatment method on any statistical or experimental basis. However, as a result of his clinical experience he strongly believes that the imitational treatment language has substantially increased his ability to improve the quality of life for his patients and himself.

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Medical Director

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In 1977, when the Veterans Administration compared Step-2 regimens in 450 mild hypertensive patients, which regimen was proven most effective?[1]

The Diagnosis and Treatment of Reye's Syndrome

National Institutes of Health
Consensus Development
Conference Statement

A Consensus Development Conference was held at the National Institutes of Health on March 2, 3, and 4, 1981, to address issues on the diagnostic criteria and treatment of Reye's syndrome.

At NIH, consensus development conferences bring together investigators in the biomedical sciences, practicing physicians, consumers, and advocate groups to provide a scientific assessment of technologies, including drugs, devices, and procedures, and to seek agreement on their safety and effectiveness.

On the first two days of the meeting, a consensus development panel and members of the audience reacted to evidence presented on the following questions:

- What are the key signs, symptoms, and laboratory findings of Reye's syndrome?
- What is the evidence for the effectiveness of the various treatments of Reye's syndrome?
- What are the clinical and experimental studies needed to advance our ability to diagnose and treat Reye's syndrome?

The members of the panel represented the disciplines involved in the diagnosis and treatment of those with Reye's syndrome. Panelists were nominated by seven specialty associations: the American Academy of Neurology, the American Academy of Pediatrics, the American Association of Neurological Surgeons, the American Society of Anesthesiologists, the American Academy of Family Physicians, the Child Neurology Society, and the American Nurses Association. This summary is the result of the panel's deliberations.

Reye's syndrome is a life-threatening illness that affects children of all ages, with a peak incidence between 5 and 15 years; on rare occasions it has been reported in adults. Although Reye's syndrome (encephalopathy with fatty degeneration of viscera) has been extensively investigated since the classic description of the disorder by Reye, Morgan, and Baral in 1963, the etiology and pathogenesis of this disease process remain obscure. The subcellular insult appears to affect mitochondria in multiple organ systems. Since prompt treatment may provide a better chance for complete recovery, early diagnosis is important.

Dissemination of information is recommended. This includes information on the early symptoms of Reye's syndrome, diagnostic criteria, and essential aspects of therapy. Such information should be distributed to parents, physicians, and nurses to facilitate early recognition, diagnosis, and treatment.

1. What are the key symptoms?

Reye's syndrome should be suspected in a child who, during or while recovering from a viral illness (most commonly chicken pox or influenza), unexpectedly develops repetitive vomiting and altered behavior such as lethargy, confusion, irritability, or

aggressiveness. Neither fever nor jaundice is usually present. In children under one year of age, respiratory disturbances such as hyperventilation or apneic episodes may be prominent. In this special group (<1 year old) seizures occur more frequently than in older patients. All children with the above pattern of illness should receive prompt medical attention.

2. What are the laboratory findings in Reye's syndrome?

Helpful laboratory tests include the level of transaminases in serum, ammonia concentration in blood, and prothrombin activity. The activity of serum transaminases is at least three times upper normal limits, prothrombin time is usually prolonged, and blood ammonia concentration is usually elevated. Jaundice is conspicuously absent and bilirubin levels rarely are elevated. The concentration of glucose in blood is usually normal, especially in children 4 years of age and older. The cerebrospinal fluid (CSF) usually contains fewer than 8 cells per mm^3 and normal protein and glucose concentrations, except when there is concomitant hypoglycemia. Other recommended laboratory tests include determination of the concentration of glucose, calcium, and phosphorus in blood and of serum amylase activity. Serum should be analyzed for levels of salicylate and acetaminophen.

3. Where should a patient be treated?

It is most important that primary care practitioners be highly aware of Reye's syndrome and perform appropriate laboratory investigations promptly. Children with a history and laboratory findings suggestive of Reye's syndrome should be hospitalized for careful observation and receive glucose by intravenous infusion. Patients with Stage II* symptoms or worse should be cared for in a pediatric intensive care unit by a multidisciplinary team according to an established protocol, when available.

If the diagnosis of Reye's syndrome is made in a primary care setting, the physician should consult with colleagues in a pediatric intensive care center and discuss the timing of transfer. The transport team should be prepared to provide support for vital functions.

4. What are the currently used rating or classifying systems for measuring the severity of clinical symptoms? How useful are they?

A variety of staging systems based upon neurologic findings have been proposed for Reye's syndrome

* Stages in this paper refer to those described in Table 1.

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?[2]

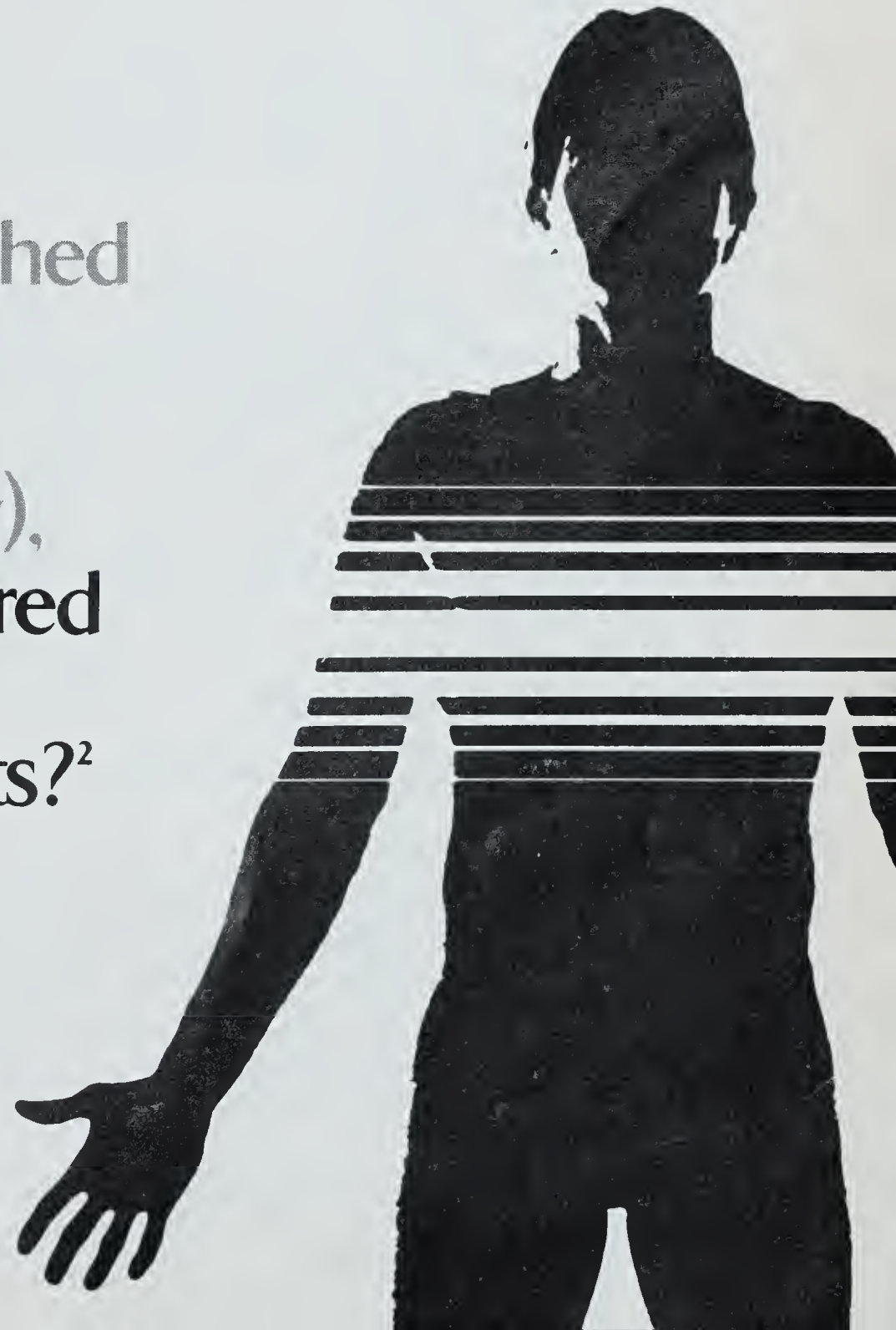

TABLE 1
STAGING OF REYE'S SYNDROME

	I	*II*	*III*	*IV*	*V*
Level of consciousness	Lethargy: Follows Verbal Commands	Combative/stupor; verbalizes inappropriately	Coma	Coma	Coma
Posture	Normal	Normal	Decorticate	Decerebrate	Flaccid
Response to pain	Purposeful	Purposeful/nonpurposeful	Decorticate	Decerebate	None
Pupillary reaction	Brisk	Sluggish	Sluggish	Sluggish	None
Oculocephalic reflex (Doll's eyes)	Normal	Conjugate deviation	Conjugate deviation	Inconsistent or absent	None

which have proven useful in assessing the severity of the illness, monitoring the effect of therapy, and predicting ultimate outcome. The multiplicity of staging systems, however, has been confusing clinicians and researchers alike.

5. Should a uniform system be recommended for general use?

The panel reviewed a number of proposed staging systems and recommends the system outlined in Table 1 for future use in management and study of Reye's syndrome. Patients with high concentrations of ammonia in blood early in the course of disease appear to have a less favorable prognosis.

6. When is a liver biopsy needed?

The diagnosis of Reye's syndrome can be made in most patients without a liver biopsy, a procedure not to be undertaken lightly in an uncooperative, critically ill child with defective coagulation. The results may confuse rather than inform unless the tissue is processed and interpreted by personnel in a center with special knowledge of the illness.

Nevertheless, a carefully planned biopsy, after correction of the coagulation abnormality, carried out by physicians experienced in performance and interpretation of the results of such biopsies, can provide important information in certain specific situations. Biopsy should be considered in: (1) infants, (2) children with recurrent episodes, (3) familial cases, and (4) nonepidemic (sporadic) cases without antecedent infection or vomiting. Biopsy also increases the certainty of diagnosis and is important if a new and potentially dangerous therapeutic regimen is planned.

7. What other conditions may present with similar symptoms?

There is a lengthening list of illnesses that may be temporarily misidentified as Reye's syndrome. We now recognize that transaminase elevations may occur in children with varicella without Reye's syndrome and in shock or hypoxia due to a wide variety of illnesses. Intramuscular injections (especially of a commonly used antiemetic, chlorpromazine) and protracted seizures may increase levels of transaminases in serum in a variety of diseases which affect the central nervous system. Methyl bromide, hypoglycin (senecio alkaloid), isopropyl alcohol, folk remedies (pyrrolizidine and margosa oil), aflatoxin, lead, and toxicity from some drugs (e.g., aspirin, acetaminophen, and valproic acid) may produce disturbances of consciousness and elevation of serum transaminases.

When confronted by familial or recurrent occurrences of Reye-like illness, the physician should consider an inborn error of metabolism, especially systemic carnitine deficiency, glutaric acidemia, ornithine transcarbamylase deficiency, or hereditary fructose intolerance.

8. What special diagnostic tests are needed?

Computerized transaxial (CT) brain scanning is neither necessary nor indicated for diagnosing Reye's syndrome unless there is clinical suspicion of a disease other than Reye's syndrome, e.g., subdural hematoma, brain abscess, etc. Thus, CT scanning is not an integral part of the diagnostic evaluation of the child with Reye's syndrome. If, however, the test is done early in the course of illness, it will show a normal pattern or evidence of diffuse brain edema, with no displacement of ventricles or localized areas of enhancement.

The usefulness of electroencephalography (EEG) depends on the availability of appropriate equipment and individuals skilled in EEG interpretation. In general, the EEG has not proved to be helpful in following patients, determining prognosis, or altering treatment.

9. What have been the indications for intracranial pressure monitoring? What devices are available? What are the goals in reducing intracranial pressure and when can monitoring be stopped?

Since 1975, several reports have several reports have suggested that invasive monitoring of intracranial pressure may be useful in the management of children with Reye's syndrome. The devices in use can provide continuous measurement of pressure in the epidural, subarachnoid, or ventricular spaces. The difficulties inherent in assessing the usefulness of this procedure, employed to monitor rather than to treat, have produced

conflicting opinions. Some physicians believe it improves their ability to manage patients, others do not. Mortality and morbidity directly attributable to monitoring devices appear to be low in the medical centers where they are used frequently. Data are inconclusive regarding criteria for discontinuation of such monitoring.

10. What are appropriate therapies in the noncomatose patient?

Therapy for Stage I patients includes administration of dextrose-containing fluid. While there are no studies documenting that glucose administration in excess of that provided by 5 per cent glucose solution at maintenance rate is definitely beneficial, a number of considerations have prompted many clinicians to administer 10 per cent dextrose solutions to these mildly affected children.

If neurologic deterioration occurs, the rate of fluid administration must be adjusted to maintain critical organ perfusion. Episodes of hypotension have been reported with maintenance rates of fluid administration following osmotic diuresis.

For many reasons, hemodynamic monitoring is important. Arterial catheters permit continuous blood pressure measurement and frequent arterial blood-gas sampling. Central venous catheters may provide useful data concerning blood volume and cardiac function, while pulmonary artery catheters (providing measurement of cardiac output) may be helpful in selected seriously ill children. While central venous catheters may be preferable in patients with normal cardiopulmonary function, the management of complicating cardiac dysfunction due to disease or drugs may make more complete monitoring necessary.

Intubation of patients with Reye's syndrome has received general acceptance, although there is disagreement as to what criteria are used to make the decision to intubate. There is agreement that intubation should be elective (i.e., prior to respiratory failure or cardiac arrest). It is most often prompted by deteriorating neurologic progression toward coma and is accomplished with intravenous succinylcholine and barbiturate.

11. What are the important metabolic derangements and are they amenable to treatment?

There are many documented metabolic derangements in Reye's syndrome, including hypoglycemia, hyperammonemia, hyperlactacidemia, short chain fatty acidemia, hypophosphatemia, hyperaminoacidemia, azotemia, hyperuricemia, elevations of several

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?[3]

hormones, and a mixed acid-base disorder. Accepting these well-documented findings and their relationship to the severity or treatment of the disease remain speculative. Although the degree of metabolic perturbation roughly parallels the severity of clinical illness, efforts (dialysis, amino acid infusion, phosphate and insulin infusions) to correct specific metabolic abnormalities have not clearly altered outcome.

Administration of vitamin K is generally accepted, although it is recognized that it is unlikely to correct fully clotting abnormalities. If significant bleeding occurs, exchange transfusion with fresh blood or administration of fresh frozen plasma may be helpful.

12. What are the therapies for increased intracranial pressure?

While the encephalopathy of Reye's syndrome is not always associated with increased intracranial pressure, such elevations frequently complicate the care of patients in coma. In lieu of specific treatment of the encephalopathy, much effort has been directed to the control of increased intracranial pressure. Measures commonly employed include osmotherapy and spontaneous or controlled hyperventilation. Experimental measures include high-dose barbiturates, corticosteroids, CSF withdrawal, and decompressive craniotomy. Use of newer techniques of monitoring and treating cerebral edema should be reserved for centers experienced in the diagnosis and management of children with severe neurologic disorders. To date, groups employing these experimental measures have failed to demonstrate better survival rates than those providing intensive supportive care.

13. What therapies are directed at removal of presumed toxins?

Exchange transfusion, dialysis, total body "washout," charcoal hemoperfusion, and plasmapheresis have all been suggested as potentially helpful by removing an unidentified toxic substance from patients with Reye's syndrome. There is no evidence that the use of these techniques improves outcome.

14. What are the residual findings?

Complete recovery may be expected in the majority of patients who survive the acute illness. However, some children who experience coma may suffer brain damage resulting in devleopmental delay, motor impairment, or mental retardation. Normal functioning in school may be delayed for some weeks. Children may be able to do the prescribed school work, but at a slower

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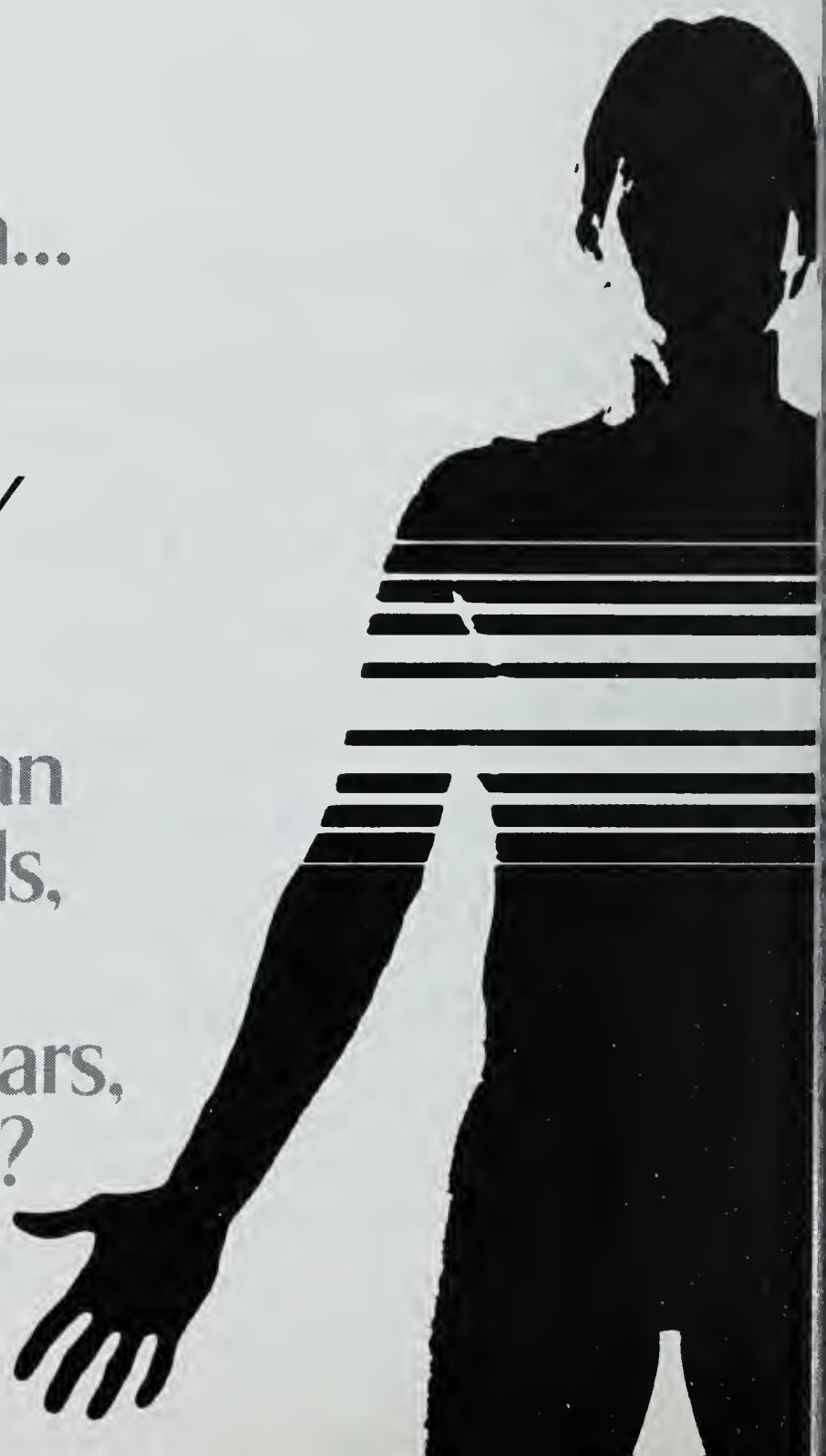

rate. Sometimes distractability, inattention, and memory problems occur.

Anxiety and apprehension associated with fear of bodily harm and death are frequently encountered in these children while hospitalized and following discharge from the hospital. Such fears can be helped by gentle parental support. Overprotectiveness of the child by the parents can accentuate behavioral or school problems and should be avoided.

Extensive psychological and educational testing appears to be unnecessary except in a study setting. Assisting school personnel in providing learning experiences geared to the individual needs of the recovering child may be required. Family guidance and counseling may be useful and are encouraged.

15. What are the areas of future research?

Potential areas of research include: epidemiology, etiology, pathogenesis, diagnosis, management, and outcome. Most important is elucidation of the etiology and pathogenesis of this syndrome, with prevention as the ultimate goal.

Epidemiology

The low incidence of this disease results in small numbers of patients available for study at any single institution. The designation of a specific diagnostic code for Reye's syndrome in the International Classification of Diseases (10th Revision, Clinical Modification) would facilitate the determination of a more accurate incidence rate for Reye's syndrome.

Studies stratifying cases by age, sex, and race, by socioeconomic and environmental characteristics, and by geographic areas and location of residence (urban, suburban, rural) are needed to elucidate factors which may be important.

Etiology

Although the etiology of Reye's syndrome remains unknown, an association with a recent viral infection, especially influenza B and varicella, is well-established. However, the development of Reye's syndrome following any of these viral infections is uncommon, and why only certain individuals develop the disease deserves further study. In addition, three recent population-based case-control studies have demonstrated an apparent association between salicylate usage and Reye's syndrome. Since the specific questions posed to the panel and discussed at the consensus conference were limited to diagnosis and treatment, the data on which this association is based were not presented but were discussed by several participants in the confer-

nd there's more proof on the way!

982 will see the completion of the Multiple Risk actor Intervention Trial (MRFIT)—a six-year, 2,000-patient study assessing the factors that crease risk of cardiovascular disease. For the anagement of hypertension, the preferred ep-2 regimen in this study is reserpine-thiazide.

1978, in a preliminary report presented to the pidemiology Section of the American Heart ssociation (Dallas, Nov 1978), after 12 months f the trial, fewer patients (5.3%) treated with serpine suffered depression than even the ntreated control group (7.7%)!

ase see references and brief summary of prescribing information on last pages of this advertisement.

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ence. Each of the three studies indicates an increase in the estimated relative risk of Reye's syndrome, which does not appear to be due to chance. However, other possible explanations of this association include the following: potential phases such as case-control selection (e.g., comparability of antecedent illness), information gathering (e.g., based on recall), and confounding (e.g., indications for salicylate use).

Parents and physicians should be aware that most, if not all, medications have potential deleterious effects; thus, caution in the use of salicylates in children with influenza and those with varicella is prudent. Currently, the risk of these effects is unknown for salicylates or for other antipyretic medications. Since salicylates have been given to children with illnesses predisposing to Reye's syndrome without adverse effect, and cases of Reye's syndrome have occurred in which salicylates had not been administered, salicylates alone cannot be responsible for the development of Reye's syndrome. However, certain similarities between salicylism and Reye's syndrome and those studies reporting an association between Reye's syndrome and salicylate ingestion indicate a need for further carefully designed studies before recommending changes in antipyretic therapy of children.

The role of influenza and other viruses, aflatoxins, and genetic predispositions also deserve study.

Diagnosis

Although guidelines for the reognition of Reye's syndrome are generally accepted, information on the validity of the many proposed screening (clinical and laboratory) tests is incomplete and based on small numbers of patients or nonuniform diagnostic criteria. Particular attention should be given to documenting the sensitivity, specificity, and predictive values associated with various tests.

Management and Outcome

Critical and comparative evaluation of the treatment of Reye's syndrome can only proceed within the framework of a randomized controlled trial. A need exists for determining the best available monitoring procedures, seeking the most sensitive indicators of patient status while exposing the patient to the minimal risk. Evaluations of treatment and monitoring regimens require strictly defined protocols and a sample size necessary for statistical analysis.

Both the short- and long-term sequelae related to Reye's syndrome should be evaluated. Subtle effects

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Brief Summary of Prescribing Information (12) 10/27/78

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WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

on mental and motor capabilities should be evaluated using longitudinal data analysis. When possible, evaluations should be conducted without knowledge of the patient's treatment or monitoring regimens.

The conference was sponsored by the National Institute of Neurological and Communicative Disorders and Stroke and co-sponsored by the National Institute of Allergy and Infectious Diseases; the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases; the National Institute of Environmental Health Sciences; the National Institute of Child Health and Human Development; and the Division of Research Resources. Collaborating agencies included the Centers for Disease Control and the National Center for Health Statistics. Assistance was provided by the Office for Medical Applications of Research, NIH.

A bibliography on Reye's syndrome is available from the Office for Medical Applications of Research, Building 1, Room 216, NIH, Bethesda, Maryland 20205. This bibliography was prepared by the Developmental Neurology Branch, National Institute of Neurological and Communicative Disorders and Stroke.

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continued on page 53

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

References:

1. Propranolol in the treatment of essential hypertension. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303-2310, 1977.
2. Five-year findings of the hypertension detection and follow-up program: I. Reduction in mortality of persons with high blood pressure, including mild hypertension. Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 242:2562-2571, 1979.
3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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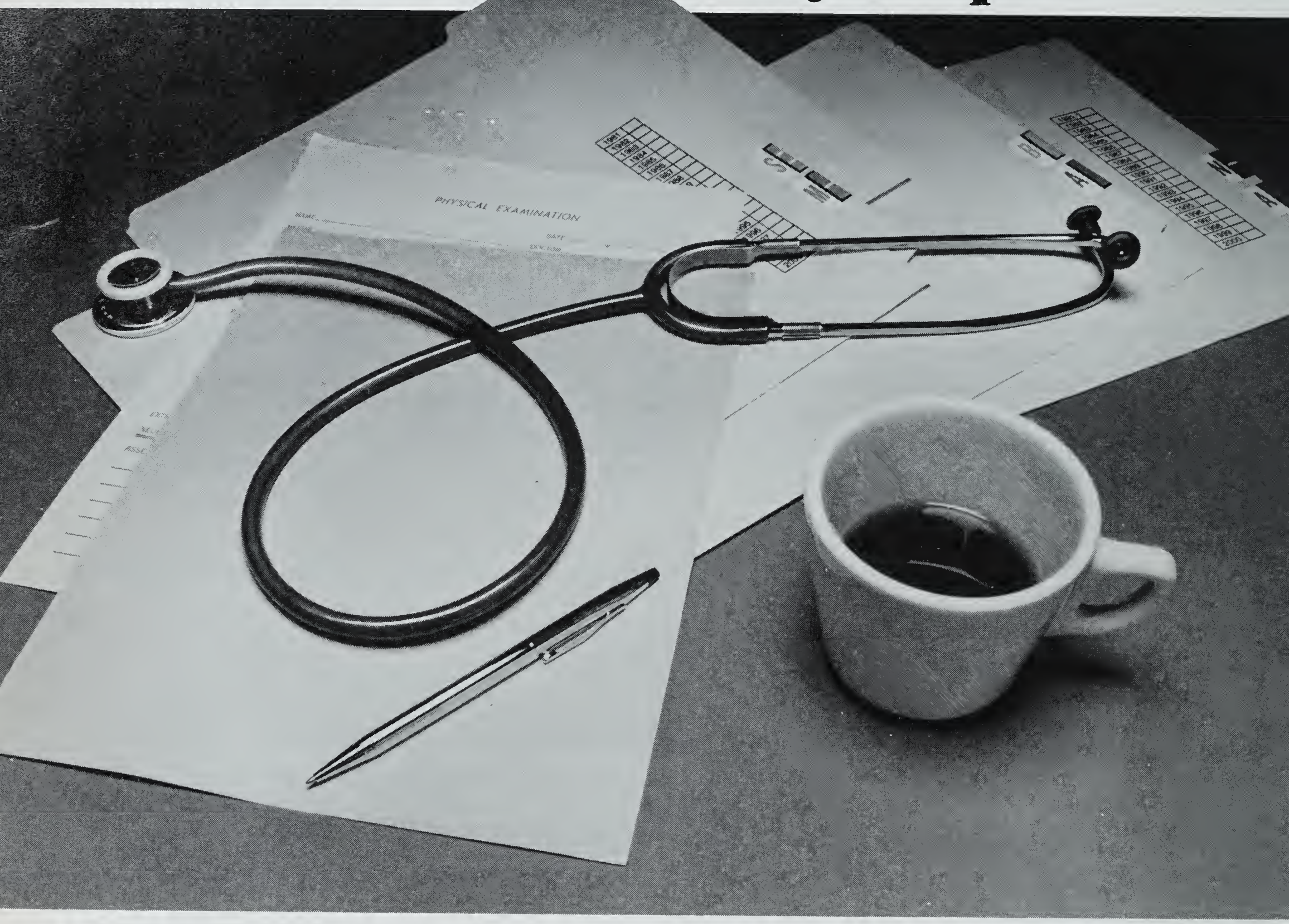

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An Early Smoking Warning

WILLIAM L. SMITH, M.D.
Editor, *The Journal*

The lower respiratory tract is protected from inhaled and aspirated microbes and particles that penetrate the aerodynamic filter system of the tracheobronchial tree by several mechanisms.

Billions of aerobic and anaerobic bacteria are inhaled and discharged from the lower tract. Yet, the parenchyma and distal airways are sterile. The mucocilliary blanket, the alveolar transport systems, and the lymphohematogenous drainage systems combine to offer this protection. Cigarette smoking adversely affects all of these defense mechanisms.

The adverse effects of smoking tobacco on the coronary arteries is well established. Further, no real doubt still remains in the minds of the enlightened that cigarette smoking and carcinoma are related. Yet, why has it taken so long for medicine to admit these obvious environmental hazards? There was ample evidence available for over a century.

The following article was published some time ago in the *Transactions* of the Association:

"While to all appearances I was perfectly well, I would without warning suddenly be seized with a sharp, stabbing pain of such violence as to stop me immediately and I was obliged to bend forward to breathe. I was examined by Dr. Dutcher of Cleveland, Ohio, who after hearing my case gave it as his opinion that the whole difficulty arose from excessive use of tobacco; that the whole difficulty arose from the gradual poisoning of the muscular activity of the heart.

"I went home; gradually abandoned tobacco; having a terrible struggle that summer. August 1, 1870, I gave up entirely the use of tobacco; the attacks grew less frequent; the whole system, physical and mental, became more vigorous and the attacks gave way entirely — it is certain that to my own mind that tobacco is a potent factor in the causations of trouble of the heart."

—*Transactions,* 1885
by Edward H. Sholl, M.D., Birmingham

The Federal Reserve System: What Is It?

Eugene Stanaland, Ph.D.

Functions of a Central Bank

The Federal Reserve System (the ''Fed'') is this country's central banking system. According to a Federal Reserve publication, the function of the system is ''to foster a flow of credit and money that will facilitate orderly economic growth, a stable dollar, and long run balance in our international payments.''

A sample of a textbook definition goes: ''An institution that creates and destroys the community's stock of money through consciously contrived policies in order to further well-understood economic goals, such as price level stability and high levels of employment.'' In other words, the central bank controls the amount of money in the economic system in order to achieve national economic goals.

Why Have a Central Bank?

Origin of Banks

The best way to understand the necessity for a central banking system is to imagine the economy without one, or the way it was before 1913 when the Federal Reserve Act was passed. Imagine the local goldsmith who owned a safe where gold and silver could be kept relatively secure. Requests were made of him to keep gold for citizens until they had need for it.

Receipts would be issued for the gold left with the goldsmith. Depositors of the gold would drop by to claim gold as they needed it for transactions or would use their receipts as a basis for payment, but left most of the gold for continued safe keeping. The goldsmith found that a rather significant amount of gold was left in the safe at all times. Some was withdrawn every day, but that was offset by deposits. Rarely did someone withdraw all of his gold at one time.

Enterprising goldsmiths realized that they could use some of that gold to make loans. It could be lent out for a period of time and returned before the original depositor claimed it. An interest income could be earned that would help to offset the cost and risk incurred to keep the gold safe for the depositors.

As a result, the goldsmith received a deserved reward and the depositor suffered no loss. How much of the deposited gold could the goldsmith safely lend without running the risk that a depositor would return and ask for gold that had been loaned? Experience showed that maybe only 15 per cent of the gold was necessary to meet the day to day withdrawals; the other 85 per cent could safely be loaned. So, by keeping 15 per cent of the gold in reserve the goldsmith was safe. This was the beginning of ''Fractional Reserve Banking.''

Paper Money Introduced

The system became more sophisticated over the years and goldsmiths became banks. Instead of dealing in gold dust and coins, the banks issued their own bank notes which promised to pay to the bearer the face amount of the note in gold when it was presented at the bank. Hence, a borrower would make a loan and receive bank notes which represented a certain quantity of gold. The notes would be used by the borrower to make a purchase. The receiver of the notes could immediately take them to the bank and demand gold for them.

Alternatively, if the receiver of the note had a great deal of confidence that the bank had sufficient gold to cover all its notes, he might hold on to the note and avoid the security problem of having the gold on hand. Recipients of bank notes were especially inclined to

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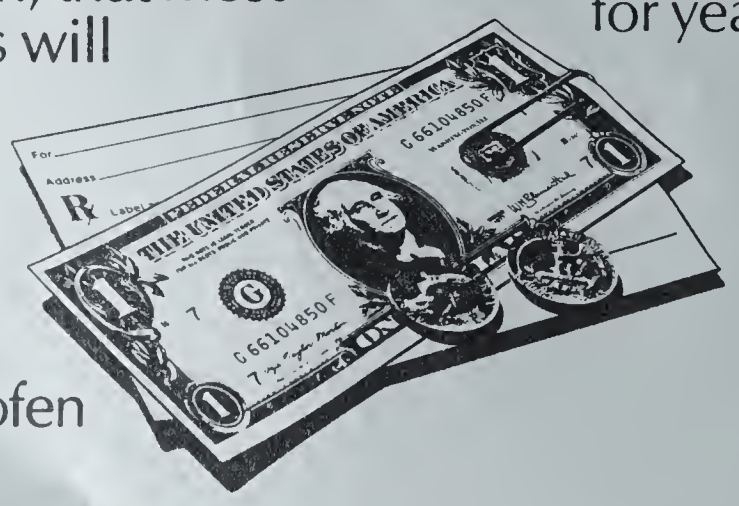

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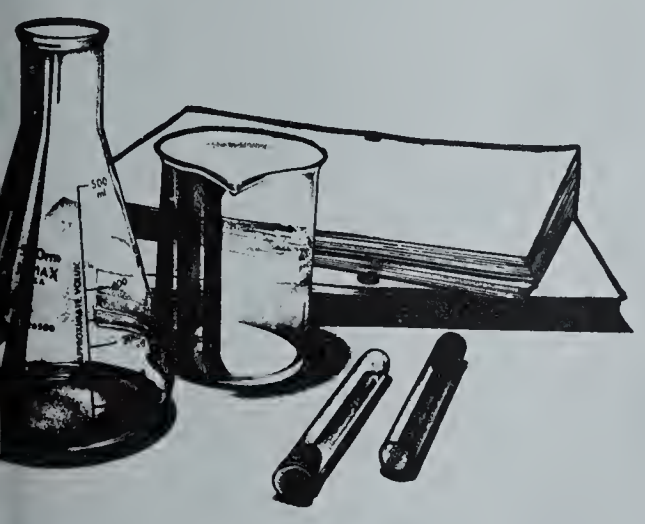

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To ensure that your patients receive the benefits of the Rufen program, *be sure to specify* "D.A.W.," "No Sub," or "Medically Necessary," as required by the laws of your state.

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John D. Bryer, President
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RF-009

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RUFEN® Tablets
(ibuprofen)

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

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Shreveport, Louisiana 71106

retain the notes if they were sure that other business people were willing to accept them at face value in payment for purchases. Fractional reserve banking had taken another step forward. It became obvious that to the extent that a bank can get the public to deal in its bank notes and not demand gold, the bank can create a rather large sum of loans using a relatively small amount of gold in reserve.

Chaos of No Control

In the ensuing years thousands of banks were started, each issuing their own bank notes. In 1865 there were 7,000 different issues of bank notes. Instead of one national currency there were thousands of different monies circulating. If one received a Farmers National Bank of Opelika note and attempted to offer it in payment for a purchase in Huntsville, Alabama, what would it be worth? If the Huntsville merchant were not acquainted with Farmers National of Opelika, he might not accept it at all. On the other hand, he might be willing to take the risk that the bank existed and that it had sufficient gold reserves to pay the note, but would demand that it be discounted for the risk he was taking and the fact that he would have to travel to Opelika to cash it in gold.

One begins to see the difficulties generated by not having a uniform currency with some stable value. Other problems were created by overzealous banks who loaned too much and did not keep a sufficient reserve to pay depositors on demand. The desire to increase the amount of income-producing loans competed with the necessity to retain sufficient ''idle'' reserves to insure security. The result was monetary chaos.

Attempts at Remedy

Efforts were made during the 19th Century to remedy the chaos by creating the First and Second National Banks, and the National Banking Act which was passed in 1863. Each of these efforts made some contribution to stability with varying degrees of success. Resentment developed in parts of the country about central banking establishments controlling the financial destiny of people throughout the rest of the country about whose financial needs they knew very little. The banking community complained of the unfair competition created by virtue of the powers granted the banks designated as National Banks.

The 1913 Federal Reserve Act

The Board of Governors

The present day Fed was developed to satisfy the deficiencies of the earlier efforts. The Fed is a compromise between the central control needed for order and stability and recognition of varying financial needs across the country. The entire structure of the Fed is a reflection of this effort. Central control is accomplished through the Board of Governors of the Fed: seven people, appointed by the President for 14 year terms, located in Washington, D.C.

The District Banks

Regional interests are represented through twelve district banks located across the country in New York, Chicago, San Francisco, Philadelphia, Boston, Cleveland, St. Louis, Kansas City, Atlanta, Richmond, Dallas, and Minneapolis.

Alabama is in the 6th Federal Reserve District and comes under the jurisdiction of the Federal Reserve Bank in Atlanta. There is a district branch bank located in Birmingham. The Federal Reserve Banks are owned by the member banks who join the Federal Reserve System. Each bank is required to buy an amount of stock in the Fed bank when it joins the system. Banks chartered by the Controller of the Currency, called National Banks, are automatically members of the Fed System. State chartered banks have the option to join.

Less than half of the approximately 15,000 banks in the country are members of the Fed, but the member banks hold some 80 per cent of all deposits in the economy. Many non-member state banks belong to the Fed's clearinghouse system for collecting checks. Almost all banks have their deposits insured through the Federal Deposit Insurance Corporation which insures deposits up to $100,000 per account.

An example of the compromise between central and decentralized control of the banking system is the make-up of the Boards of Directors of the Federal Reserve Banks. There are nine directors. The Board of Governors appoints three of the directors who represent the public view on the board; the other six directors are elected by the member bank owners, three of whom represent the banks and the other three chosen from the business community.

The Federal Open Market Committee (FOMC)

The Open Market Committee is charged with responsibility for managing the Fed's portfolio of government bonds. They represent the most important power in the system regarding changes in the money supply. The FOMC is made up of 12 members: seven members of the Board of Governors and five Federal Reserve District bank presidents — another sign of the compromise of central and decentralized control. The President of the New York District Bank is always a member of the committee because open market sales and purchases are conducted through that bank. The other four positions are held by presidents of the other District banks on a rotating basis for one-year terms.

The Federal Advisory Council

The Federal Advisory Council is a group of twelve people selected by the presidents of the District banks who meet about four times a year in Washington to

converse with the Board of Governors. They serve in an advisory capacity only. Their existence is a further effort to insure that the central controlling body is attuned to the needs and circumstances of people across the country.

What the Fed Does

Monetary Policy

The function of the Federal Reserve System is to formulate a monetary policy that will control the supply of money in the economy to achieve the goals of a stable value of money and provide for the growth of the economy. The Fed has a number of tools available to achieve these objectives. All of these tools are directed toward the reserves available to the commercial banks. These reserves are the determining factor in the amount of demand deposits (money) the banks can create by making loans.

Reserve Requirements

The Fed sets the amount of money the commercial banks must keep on deposit in the District bank to ''back'' the demand deposits they place on their books through making loans. This reserve requirement has hovered around 15 per cent in recent years although the law permits the Fed to set it between 7 per cent and 22 per cent.

This is a powerful tool because it has an immediate and direct effect on the bank's ability to lend money. If a commercial bank had deposits on its books in the amount of $1,000,000, its reserve requirement under the 15 per cent rule would be $150,000. Suppose the Fed raised the reserve requirement to 18 per cent or $180,000. Immediately the bank would begin to contract its loan activity to bring its reserves up to $180,000. It is the sudden and direct impact described here that causes the Fed to move the reserve requirement infrequently and by small amounts.

The Discount Rate

When commercial banks are in need of money they use the Federal Reserve banks as their bank. If a bank gets ''loaned up,'' i.e., loans out the maximum it can and is bumping up against its reserve requirement, they go to the Federal Reserve bank for a loan. The Federal Reserve Bank charges the bank an interest charge for the loan which is called the discount rate.

When the Fed wants to discourage loans and reduce the amount of money in the system, they increase their discount rate to the banks. When they want to encourage loans, they decrease the rate.

Open Market Operations

The most signficant tool used by the Fed is the purchase and sale of government bonds in the open market through the New York Bank as directed by the Federal Open Market Committee. When the FOMC wants to increase the amount of money in the system it will direct the New York Bank to buy bonds in the market.

The Fed approaches bond holders and offers a price sufficient to prompt a sale, offering the seller a check written on the Fed bank and taking the bond. The check is deposited by the seller in his local bank which sends the check to the Fed Bank to be collected. The Fed Bank pays by adding the amount of the check to that bank's reserve account. The commercial bank's lending ability has just been increased. The Fed has taken a non-money item, a bond, out of the system and replaced it with a demand deposit which is money.

When the Fed wants to decrease the money supply, the FOMC directs that bonds be sold. They enter the market and offer bonds which are paid for by a check drawn on a local bank. The Fed collects the check by deducting the amount from the local bank's reserve account. That bank's ability to create deposits has been reduced. The Fed has taken a money item, a demand deposit, out of the system and placed a non-money item, a bond, in the system thereby decreasing the money supply.

Direct Controls

Some other control powers the Fed has include: 1) they set the maximum rates that can be paid on savings accounts; 2) they set margin requirements, that is the proportion of the price of a share of stock that one is allowed to borrow to buy that stock; 3) the Fed can also set terms on installment or mortgage credit such as requiring larger downpayments and restricting the length of the payback period. These installment credit regulations are used infrequently and usually only in emergency conditions such as war.

The Effectiveness of the Fed

One of the most frequently discussed and most disagreed upon subjects talked about in our society is whether the Fed is a contributor to or a solution for our economic problems. The Congress has threatened to change the law to place monetary policy in the hands of people who would be subject to election periodically and hence ''more sensitive'' to the people.

Few would hold that the Fed has performed without error. However, it can also be said that they have been the only offset to the inflationary deficit spending behavior of our elected, ''responsive'' congressmen. It would be a sad day when the Fed was placed in a position of pressure to get reelected by a citizenry that says the way to get relected is to give me more and don't charge me for it. That kind of pressure has led to constant deficits which feed inflation.

Recent high interest rates created by the Fed's monetary policy appear to be an absurd contradiction. How does one explain a government agency committed to fighting inflation purposely increasing one of the

prices that makes up our cost of living — the price of borrowed money? It appears that they are adding to inflation, not combatting it.

To understand, imagine the opposite policy of loose money and reduced interest rates. The result would be an increase in borrowing, more money pumped into the system, both of which would lead to increased demand pressure for a stock of things to buy that is not growing sufficiently to meet the present level of demand, which is causing prices to be bid higher.

A loose money policy would bring higher price levels and eventually higher interest rates as lenders demanded a greater premium to offset the decline in the value of their money that the inflation brings. So, what appears to be a contradiction turns out to be appropriate monetary policy.

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Hazards of Marijuana — A Psychiatrist's Viewpoint

Ronald C. Bloodworth, M.D.*

Marijuana is an ancient drug of abuse. It became a major problem in the 1960s and has continued to occupy a significant threat to the user.

There are many myths, misconceptions, misinformation and mistakes about marijuana. It may be unfortunate that marijuna is not a ''sensational'' drug such as LSD or PCP, because it seldom makes headlines or TV shows. Its influence and effects are insidious and malignant, nonetheless.

The primary active ingredient in marijuana is delta-9-tetrahydrocannabinol or THC. When smoked, approximately 50% is absorbed, contrasted with 5 to 10% absorption orally. It has a biphasic pattern in the plasma with high levels initially, which rapidly disappears due to high lipid solubility and then a gradual slow release from the lipid stores. The half-life of THC is 7 days. The organs of the body with high lipid concentration tend to concentrate the THC and slowly excrete it, requiring approximately 30 days for complete elimination.

Tolerance develops rapidly and the smoking of 3 joints a week can easily lead to escalation in order to achieve the desired results. Dependence may be categorized as being either psychological or physical. There is considerable data to indicate the use of marijuana results in psychological dependence. Evidence is also accumulating that a low-grade physical dependence can also occur, but due to the long half-life and gradual excretion, acute signs and symptoms of withdrawal, similar to narcotic, barbiturates or alcohol, are not seen. Abruptly discontinuing chronic marijuana use can result in irritability, anxiety, insomnia, anorexia, and malaise.

I would like to focus primarily on the psychological and neuroendocrine effects marijuana has on the individual. Use of marijuana can lead to significant disruptions in the ego — especially in adolescents at a time when tremendous endocrine and neuroendocrine changes are occurring. By electron-microscopy, Heath at Tulane Medical School has demonstrated damage to the nerve cell membrane which may be irreversible as a sequela of marijuana use.

THC has a direct pharmacological effect on the brain, especially on the limbic system and hypothalamus. Neuro-hormonal influence is manifested by decreases in follicle-stimulating hormone and luteinizing hormone. There have also been cases of elevated prolactin levels, which resulted in gynecomastia in males. Females have demonstrated menstrual irregularities and decreased fertility. Males may show a decrease in serum testosterone, a diminished sperm count with decreased mobility, and an increased number of abnormal sperm.

Although marijuana is touted as being a facilitator in

* Director, NeuroPsychiatric Evaluation Unit; Clinical Director, Psychiatric Institute of Atlanta, Atlanta, Georgia.

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†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.
2. Multicenter trials. Data to be published.

See important information on page after next.

Compared to ampicillin

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. . . in adults and children

Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.[3]

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†Due to susceptible organisms.
3. Data on file, Wyeth Laboratories.

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Philadelphia, Pa. 19101

Cyclapen®-W (cyclacillin)

Indications
Cyclocillin hos less in vitro octivity than other drugs in the ampicillin closs ond its use should be confined to these indicotions: Treotment of the following infections:

RESPIRATORY TRACT

Tonsillitis ond phoryngitis coused by Group A beto-hemolytic streptococci

Bronchitis ond pneumonio coused by *S. pneumoniae* (formerly *D. pneumonioe*)

Otitis medio coused by *S. pneumoniae* (formerly *D. pneumonioe*) ond *H. influenzoe*

Acute exocerbotion of chronic bronchitis coused by *H. influenzoe**

*Though clinicol improvement hos been shown, bocteriologic cures connot be expected in oll potients with chronic respirotory diseose due to *H. influenzoe*.

SKIN AND SKIN STRUCTURES (integumentory) infections coused by Group A beto-hemolytic streptococci ond stophylococci, non-penicillinose producers.

URINARY TRACT INFECTIONS coused by *E. coli* ond *P. mirabilis*. (This drug should not be used in ony *E. coli* ond *P. mirobilis* infections other thon urinory troct.)

NOTE: Perform cultures ond susceptibility tests initiolly ond during treotment to monitor effectiveness of theropy ond susceptibility of bocterio. Theropy moy be instituted prior to results of sensitivity testing.

Contraindications Controindicoted in individuals with history of on ollergic reoction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of ontibiotics moy promote overgrowth of nonsusceptible orgonisms. If superinfection occurs, toke oppropriote meosures.

PREGNANCY: Pregnoncy Cotegory B. Reproduction studies performed in mice ond rots ot doses up to 10 times the humon dose reveoled no evidence of impoired fertility or horm to the fetus due to cyclocillin. There ore, however, no odequote ond well-controlled studies in pregnont women. Becouse onimol reproduction studies ore not olwoys predictive of humon response, use this drug during pregnoncy only if cleorly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in humon milk. Becouse mony drugs ore, exercise coution when cyclocillin is given to o nursing womon.

Adverse Reactions Orol cyclocillin is generolly well toleroted. As with other penicillins, untoword sensitivity reoctions ore likely, porticulorly in those who previously demonstroted penicillin hypersensitivity or with history of ollergy, osthmo, hoy fever, or urticorio. Adverse reoctions reported with cyclocillin: diorrheo (in opproximotely 1 out of 20 potients treoted), nouseo ond vomiting (in opproximotely 1 in 50), ond skin rosh (in opproximotely 1 in 60). Isoloted instonces of heodoche, dizziness, obdominol poin, voginitis, ond urticorio hove been reported. (See WARNINGS) Other less frequent odverse reoctions which moy occur ond ore reported with other penicillins ore onemio, thrombocytopenio, thrombocytopenic purpuro, leukopenio, neutropenio ond eosinophilio. These reoctions ore usuolly reversible on discontinuotion of theropy.

As with other semisynthetic penicillins, SGOT elevotions hove been reported.

As with ontibiotic theropy generolly, continue treotment ot leost 48 to 72 hours ofter potient becomes osymptomotic or until bocteriol erodicotion is evidenced. In Group A beto-hemolytic streptococcol infections, ot leost 10 doys' treotment is recommended to guord ogoinst risk of rheumotic fever or glomerulonephritis. In chronic urinory troct infection, frequent bocteriologic ond clinicol opproisol is necessory during theropy ond possibly for severol months ofter. Persistent infection moy require treotment for severol weeks.

Cyclocillin is not indicoted in children under 2 months of oge.

Potients with Renol Foilure Cyclocillin moy be sofely odministered to potients with reduced renol function. Due to prolonged serum holf-life, potients with vorious degrees of renol impoirment moy require chonge in dosoge level (see DOSAGE AND ADMINISTRATION in pockoge insert).

Dosage (Give in equolly spoced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Troct		
Tonsillitis & Phoryngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis ond Pneumonio		
Mild or Moderote Infections	250 mg q.i.d.	50 mg/kg/doy q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/doy q.i.d.
Otitis Medio	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Urinory Troct	500 mg q.i.d.	100 mg/kg/doy

*Dosoge should not result in o dose higher thon thot for odults.
†depending on severity

How Supplied Tablets 250 mg ond 500 mg in bottles of 100. Orol Suspension 125 mg ond 250 mg per 5 ml in bottles to moke 100 ml ond 200 ml of Suspension.

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interpersonal relations, the *American Journal of Psychiatry,* July, 1979, in a well controlled study, clearly demonstrated the use of marijuana to result in insecurity, confusion, detachment, and a subsequent deterioration of interpersonal relations. There has been a sharp increase in the use of marijuana in middle school years. This, associated with an attitude of permissiveness and erroneous acceptance as an innocuous drug, has resulted in many psychiatric casualties.

There have been statements that marijuana does not lead to other drug use. Data continues to accumulate that alcohol and marijuana are frequent confederates and are synergistic. As a result of peer pressure, experimentation and/or intentional or accidental use, the person may also be exposed to PCP, cocaine, narcotics, amphetamines or central nervous system depressants. Marijuana is frequently adulterated with other drugs or chemicals to give a "better high."

One of the most insidious and malignant effects of marijuana was recognized in Egypt 150 years ago by Moreau who noted a decrease in psychomotor activity, decreased motivation, and physical and psychological deterioration with the use of hashish, the resin of the marijuana plant. The literature is filled with examples of "Amotivational Syndrome" of marijuana. This is also correlated with a deterioration in a person's self-concept and his moral value system. Decreased inhibitions, increased suggestibility, impairment of judgment, create an extremely vulnerable and malignant condition. This syndrome is particularly dangerous, since significant developmental milestones may be delayed or never accomplished, resulting in impaired interpersonal function.

Emergency rooms, more often than psychiatrists, see episodes of acute panic or severe anxiety attacks secondary to marijuana. Organic brain syndromes induced by marijuana present with confusion, disorientation, memory impairment, difficulties in concentration and attention span.

There is little question that genetic influences play a role in certain psychiatric illnesses, such as schizophrenia and primary affective disorders, and an increased body of knowledge points to the role of altered central nervous system neurochemistry. It is, therefore, not surprising that marijuana may precipitate major psychotic episodes, such as acute schizophrenic episodes, severe depressions, or an acute manic episode. It is extremely rare to see an adolescent on a psychiatric unit who has presented with signs and symptoms of depression, acute disorganization, severe family strife, or antisocial behavior, who is not a regular marijuana smoker.

People with a schizophrenic illness seem to suffer a particular level of susceptibility to the effects of marijuana. I have personally treated a number of people who suffered from a schizophrenic illness which was well-controlled by psychotherapy, chemotherapy, or a

combination of the two, who showed severe exacerbation of their illness upon ''casual'' or ''social'' use of marijuana. In this group, marijuana is definitely contraindicated.

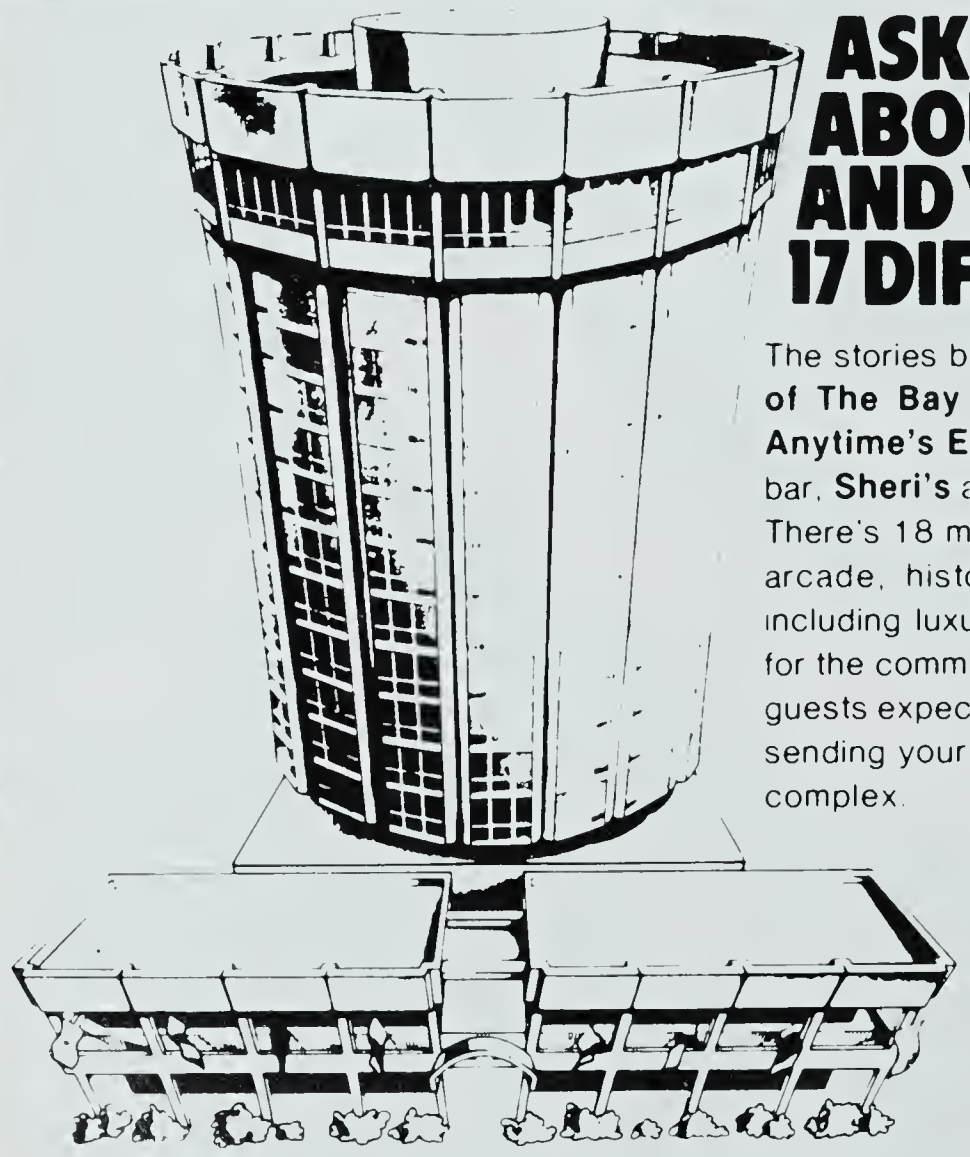
Episodes of primary affective disorders, such a major depressions or acute manic episodes, may also occur in conjunction with marijuana. These require intensive intervention and frequently set the stage for future affective episodes.

Chronic heavy users of marijuana frequently demonstrate ''soft'' neurologic signs on neuro-psychological testing, which occasionally are irreversible. Impairment of cognition, overt thought disorders, restriction of affect, poverty of mood, and dampening of normal alerting signals of danger, produce a picture of marked vulnerability to major psychiatric illness.

This is far from being comprehensive in coverage of the damage marijuana can cause, but is only intended to acquaint you with the destructive potential of this drug. Although there may be an increasing attitude of permissiveness in the general public, there is a growing body of scientific knowledge accumulating evidence against marijuana.

In January, 1980 issue of the *Journal of the American Medical Association,* it is specifically stated that the evidence against marijuana is growing, and urged a more tightly controlled future. I feel the medical community has an obligation to the public to combat the myth of marijuana, and that education of oneself and one's patients are paramount in primary prevention.

This article is a reprint from *Atlanta Medicine,* Bulletin of the Medical Association of Atlanta, Atlanta, Georgia; October, 1981; pp. 40-42.



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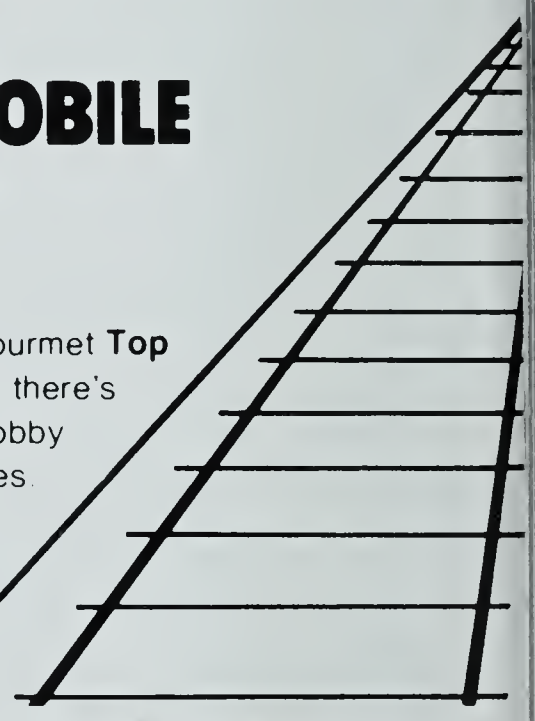

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Stone Manipulation: A Fourteen-Year Look

William H. Cooner, M.D., B. R. Mosley, M.D., Charles L. Rutherford, Jr., M.D., Jeff H. Beard, M.D., and Harry S. Pond, M.D.*

Introduction

An evaluation is made of 604 cystoscopic ureteral stone manipulations done over a 14-year period from Jan. 1, 1966, through Dec. 31, 1979. Success rate and complications are considered as they relate to stone size and location and to basket type. Practical suggestions are offered for improving the chance of stone retrieval and minimizing complications.

It is emphasized that this study reviews stone manipulations as a procedure per se, with no attempt at comparison with management by other means. A study by Mahon and Waters[1] in 1973 reviewed in a similar way their experience with stone manipulation, as well as the work of others prior to that time. In 1973, Henry and Tomlin[2] reported their data relative to manipulation as a part of their overall review of stone disease.

These 604 manipulations carried out by 5 surgeons of our clinic, whose practices encompass a total of 569 surgeon-months in the time span of this study, works out to a mean of 1.06 manipulations per surgeon per month.

* Mobile Urology Group, Mobile, Alabama.
Reprint Requests to: William H. Cooner, M.D., 1720 Center Street, Mobile, Alabama 36690.

Presented at 1980 meeting of Southeastern Section, American Urological Association, San Juan, March 23-27, 1980.

Materials

There were 552 patients in the group, of whom 401 (72.6 per cent) were male, and 151 (27.4 per cent) were female, with a male to female ratio of 2.65 to 1. Of the 604 manipulations performed, 448 (74.2 per cent) were carried out in males, and 156 (25.8 per cent) in females. Of the 552 patients, 505 had only 1 manipulation, 43 had 2 manipulations, 3 patients underwent 3 manipulations, and 1 patient had 4 manipulations. The mean age of the patients at the time of manipulation was 40.9 years for males, 39.0 years for females. The youngest patient in the series was a 9-year-old male, and the oldest was a 95-year-old female. A total of 67.2 per cent of the manipulations were carried out between the ages of 21 and 50. Twenty-two patients had a history of spontaneous passage of stone from the same ureter before manipulation, while 25 passed a different stone from the same ureter at some date after manipulation. Most (88.4 per cent) of the manipulations were carried out within 4 days after admission.

Of the retrieved stones, 409 were analyzed crystallographically. Ninety-three per cent were calcium oxalate, either pure or mixed with hydroxyl apatite. Uric acid was the stone type in 2.7 per cent. While analysis of the recovered stones creates interesting statistics, the information obtained was of relatively little value in clinical evaluation or management of the patient, since

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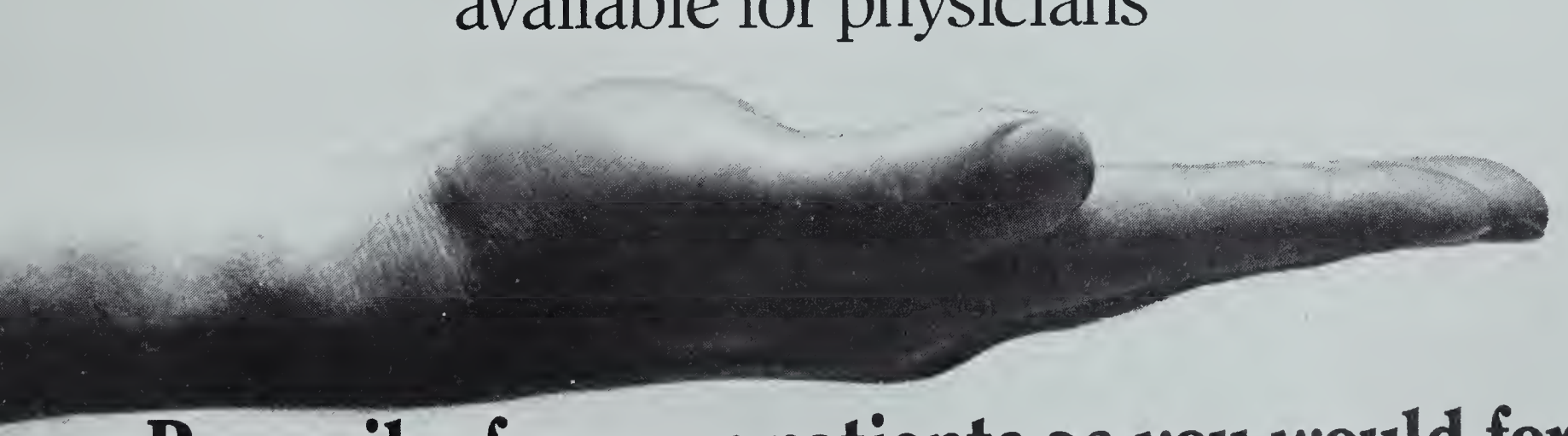

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Motrin® vs aspirin w/codeine...
(ibuprofen)

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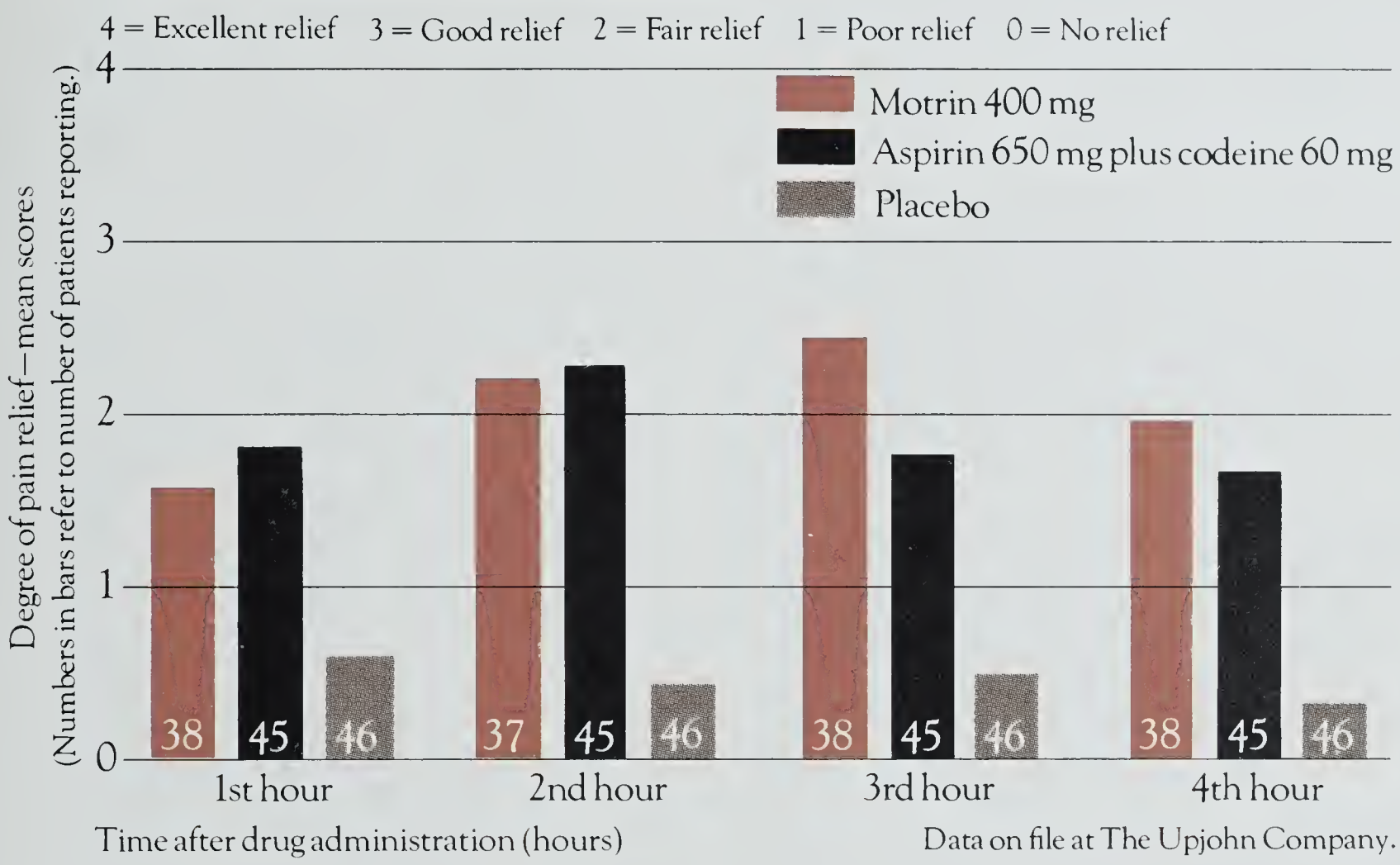
compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



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One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea;* epigastric pain;* heartburn;* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness;* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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Kalamazoo, Michigan 49001 USA

MED B-4-S

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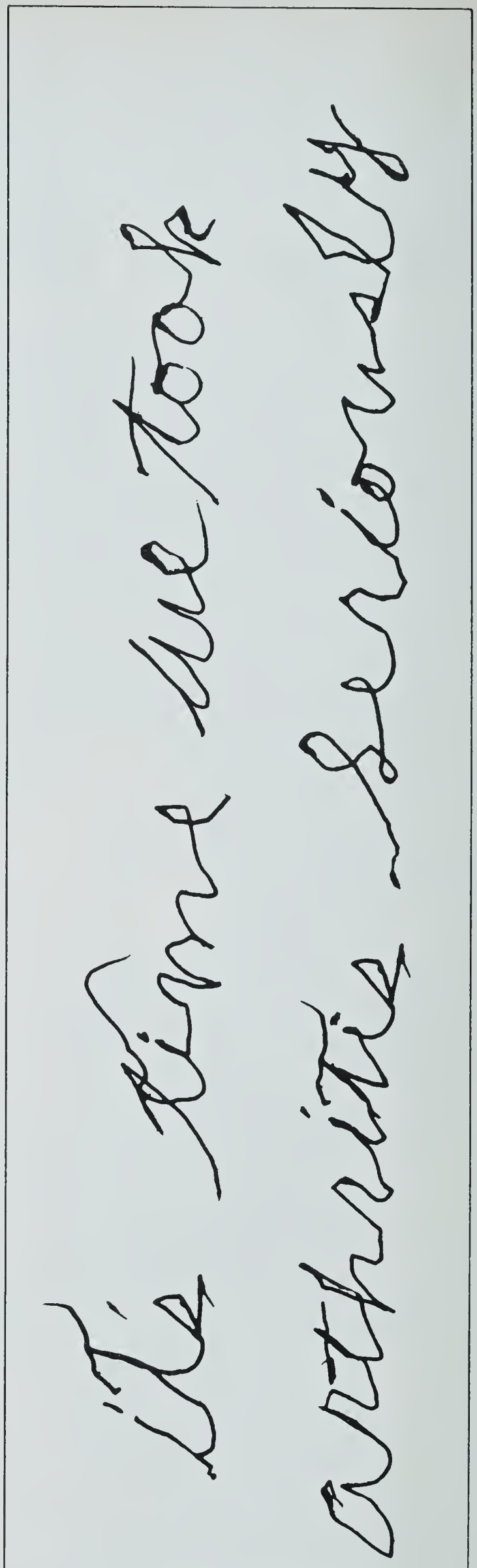
MARCH 1981



It's a myth that arthritis is just the minor aches and pains of old age. It's a major crippler that attacks. Anybody. Anytime. 31 million Americans have it. There are almost a million new cases a year. And six out of ten are under 60. Symptoms can come and go for years. So if you don't know the warning signals, find out. If you'd like information that could help you—or you'd like to help us—write to the Arthritis Foundation, Box 19000, Atlanta, GA 30326.

ARTHRITIS FOUNDATION

information about metabolic abnormalities or infection was generally obtainable by other means. While many of these stones were analyzed when the charge was less than the current $24.00, the expenditure for analysis of these 409 stones would have been $9,816 at current prices and probably is not medically needed.

Results

Of the 604 manipulations, 521 (86.3 per cent) resulted in successful extraction, while 83 (13.7 per cent) were unsuccessful.

Sex. In males, 387 of the 448 manipulations resulted in successful extraction (86.4 per cent). In females, 134 of 156 manipulations were successful (85.9 per cent).

Side. Stones were on the right side in 310 of the manipulations (51.3 per cent), and on the left in 294 (48.7 per cent). Successful extraction was accomplished on the right in 263 instances (84.8 per cent success rate), and on the left in 258 (87.8 per cent success rate).

Stone size. Stone size was determined by radiographic measurement, and of the 522 stones where size was recorded, 90 per cent were 6 mm. or less in greatest diameter. Twenty-seven stones were removed by unroofing a ureterocele or resection of the ureteral orifice overlying a contained stone. Since all of the stones manipulated in this manner were retrieved, and since the procedure is quite different from actual insertion of a basket into the ureter, these 27 manipulations have been eliminated in consideration of success rate relative to stone size. Retrieval rate remained about the same for stones up to and including 7 mm. Above 7 mm., although the number manipulated is small, the retrieval rate is much lower (16.7 per cent of 6 stones).

Basket type. The baskets employed were the four wire Dormia with filiform (88.7 per cent success with 292 stones), the four wire Cook with filiform (91.8 per cent with 183 stones) the 5 Fr. Davis loop (89.4 per cent with 47 stones), or the standard Johnson (100 per cent with 6 stones). If the stone could not be retrieved with one type of basket, changing basket types resulted in retrieval of only about 25 per cent of the stones, with a slight edge for the Davis loop as the secondary basket.

Retrieval rate relative to time of onset of symptoms. Using the onset of symptoms as the indication of when the stone dropped into the ureter, retrieval rate if manipulated during the first 2 weeks was 87.1 per cent, with little variation by day during that period. For stones manipulated between 15 days and 2 years, the success rate was slightly less (78.7 per cent).

Length of hospitalization after manipulation. We consider 2 days to be the maximum standard post-extraction hospital stay. In the extraction group, 5.6 per cent exceeded the 2 day norm for reasons related at least in part to the extraction (Fig. 1), while 77.1 per cent of the manipulations without extraction stayed longer than 2 days, this being principally related to the need for

FIGURE 1
REASON FOR HOSPITALIZATION POST-EXTRACTION GREATER THAN 2 DAYS

Total for reasons related to extraction		58
Subsequent TUR-P	6	
Medical problems	52	
Total for reasons attributable at least in part to extraction		29
Pain	14	
Hematuria	3	
Pyelonephritis	10	
Ureteral avulsion	1	
Ureterocutaneous fistula	1	

further definitive stone management. Additionally, 18 patients required readmission following initial discharge after extraction for reasons attributable to extraction (pain — 15 patients, acute prostatitis — 1 patient, hematuria — 2 patients). Thus, 9 per cent of the patients post-extraction either required hospitalization longer than 2 days or readmission for reasons related to the extraction.

Fate of stones not retrieved. Of the 83 stones which were manipulated but not successfully retrieved, 54.2 per cent subsequently passed spontaneously, 37.5 per cent required ureterolithotomy, and 4.8 per cent were subsequently successfully basketed.

Follow-up IVP. Following 176 of the manipulations or extractions, an IVP was done for a variety of reasons. The only abnormal findings in the manipulated ureter were in patients who had an IVP done within a few days after the procedure, and 4 of these showed some ureteral stasis. The others, some done several years after manipulation or extraction, showed the manipulated unit to be normal.

Complications

There were no deaths in the series. Forty-seven extractions or manipulations (7.9 per cent) resulted in complications (Fig. 2), most of which were minor.

There were 3 major complications in the group of 604 manipulations, a major complication rate of 0.5 per

FIGURE 2
COMPLICATIONS OF EXTRACTION AND MANIPULATION

	Number of Procedures	*%*
Pain (requiring hospitalization greater than 2 days or readmission)	29	4.8
Hematuria (requiring hospitalization greater than 2 days or readmission)	5	0.8
Acute pyelonephritis	10	1.7
Acute prostatitis	1	0.2
Ureterocutaneous fistula	1	0.2
Ureteral avulsion	1	0.2
Total complications	47	7.9

DRAMATIC NEW CLINICAL PROOF*

In the treatment of impetigo–

- **100% cure rate with Tegopen®** (cloxacillin sodium)
- **only a 60% cure rate with penicillin V-K**

As seen on admission

After one week of penicillin V-K therapy

Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth All 14 healed, regardless of which antibiotic was administered.	(14 patients)	9	5
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus,* 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes,* and 1% beta-hemolytic *Streptococcus*.‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:

Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:

The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:

Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:

Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

SUPPLIED:

Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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Bristol Laboratories
Division of Bristol-Myers Company
Syracuse, New York 13201

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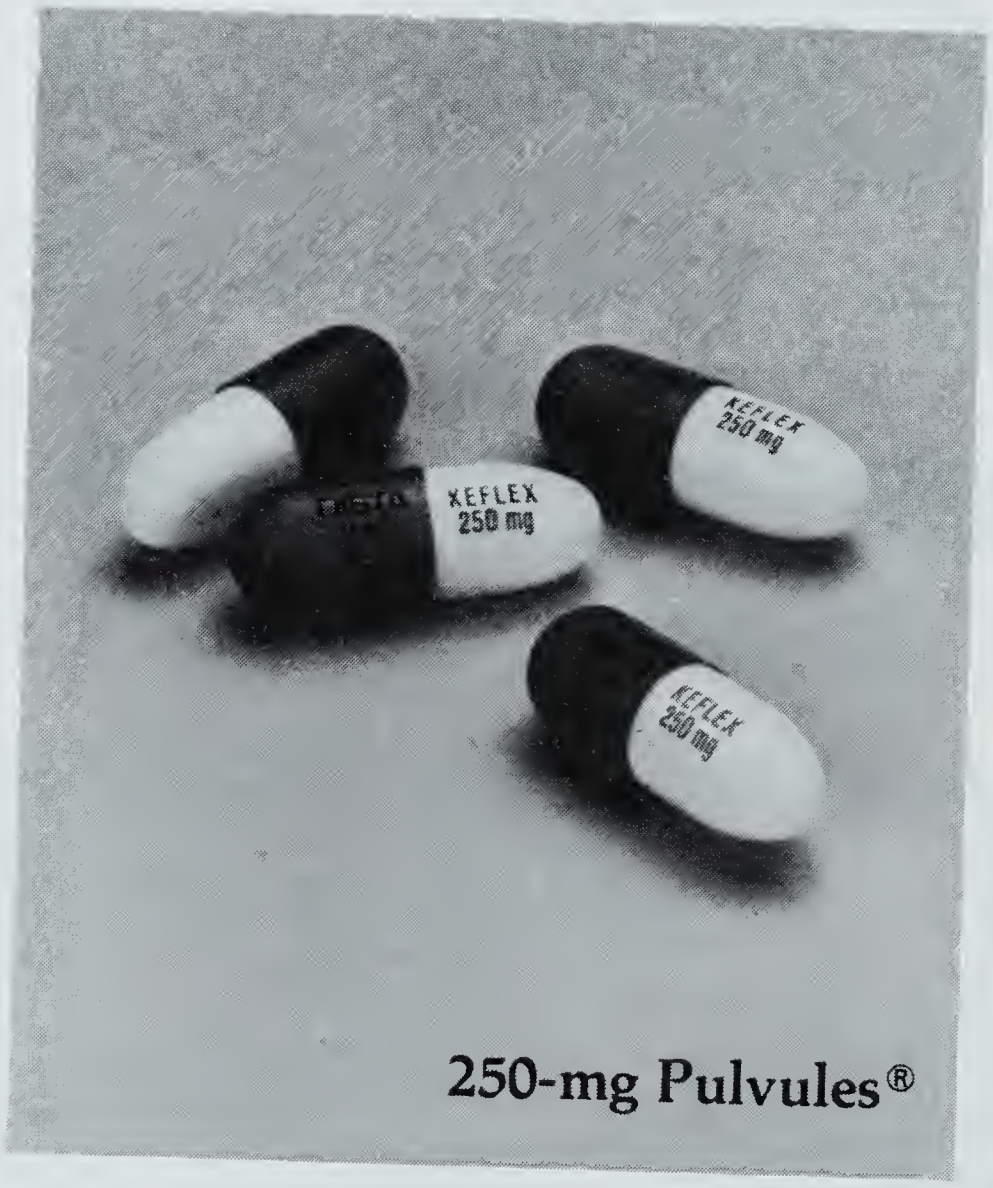

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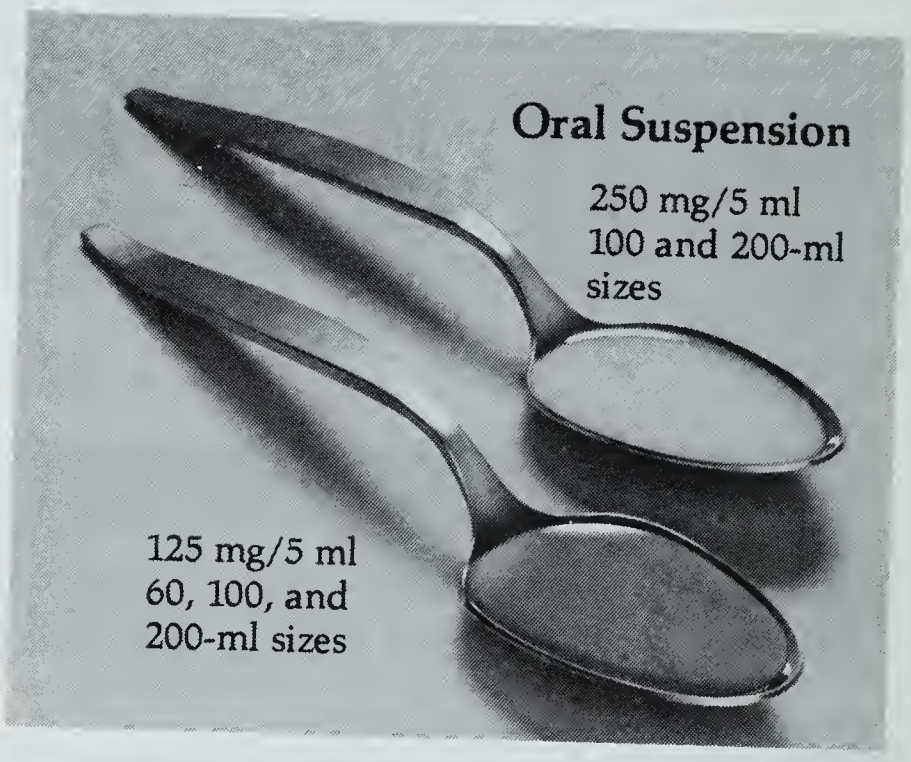

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cent. Two patients required nephrectomy, and one necessitated ureteral reimplantation.

One patient developed acute, fulminating pyelonephritis due to an organism known at that time as Eugonic oxidizer 1, which has subsequently been reclassified as Pseudomonas multivornas. At the time, in 1968, this organism was resistant to all antiobiotics then available, and the patient did not respond to empirical administration of massive doses of drugs. Nephrectomy was required as a life-saving measure.

One patient, who had an unsuccessful extraction, underwent ureterolithotomy 2 days later. There was prolonged wound drainage, and the retrograde insertion of a ureteral stent was not possible. Nephrectomy was performed.

One patient had avulsion of the mucosa of the distal ureter and was managed by immediate ureteral reimplantation. IVP 2 years later was normal.

Technique

The technique of stone manipulation is well known and requires no elaboration. However, several points, we believe, are worth emphasis in helping to achieve stone retrieval and in reducing possible complications.

1. Insist on a pristine basket, one undamaged by prior use.
2. Use a cystoscope sheath large enough to permit simultaneous passage of the basket and cystoscopic scissors or cystoscopic foreign body forceps.
3. Coat the basket tip or filiform lightly with sterile petroleum jelly.
4. After opening the basket in the ureter proximal to the stone, withdraw the basket in short pulls by pulling out the entire cystoscope about 1 cm. and then advancing the cystoscope over the basket shaft while holding gentle traction on the basket shaft. This gives the cystoscopist better tactile sensation than if the basket shaft is pulled out against the resistance of the rubber gasket as the shaft is withdrawn.
5. Use of a panendoscope without a lid gives better tactile sensation than use of one with a lid. If an instrument with a lid is used, keeping the lid in the flat position during basket withdrawal gives a better opportunity for feeling the engaged stone than when the lid impinges upon the basket shaft.
6. If the stone is tight in the ureteral meatus, incision of the meatus with cystoscopic scissors between the wires of the basket with the stone still engaged helps to prevent avulsion of the ureteral mucosa or subsequent traumatic edema of the orifice.
7. After the stone has been withdrawn into the bladder, loss of the stone can be minimized by engaging it with cystoscopic foreign body forceps, and then removing the working element, forceps, and engaged stone as a unit.
8. It is important to ''hold your mouth just right'' during the manipulation, or you won't get the stone even utilizing these fine points of the art.

Conclusions

1. Males outnumbered females in a ratio of 2.65 to 1.
2. Mean age for males and females was about the same.
3. Retrieval was not sex related.
4. Retrieval rate was not side related.
5. Retrieval rate was about the same for stones measuring 1 through 7 mm. Above 7 mm the retrieval rate was lower except for stones removed by resection of the ureteral orifice.
6. Retrieval rate was about the same for all types of baskets used.
7. The chance of retrieval of a stone by changing basket types at the same manipulation is only about 1 in 4.
8. The retrieval rate was only slightly better if manipulation was carried out within 2 weeks of symptom onset rather than later.
9. The vast majority of patients were discharged from the hospital within 48 hours after extraction.
10. Fifty-four per cent of stones not retrieved with a basket subsequently passed spontaneously.
11. There were no deaths in the series.
12. The complication rate (major and minor) was 7.9 per cent.
13. The major complication rate was 0.5 per cent.
14. Analysis of the stones retrieved was not thought to be cost effective.

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1. Mahon F. B. and Waters R. F.: A critical review of stone manipulation: a 5-year study. J Urol 110:387, 1973.
2. Henry, H. H. and Tomlin, E. M.: Ureteral calculi: review of 17 years of experience at a community hospital. J Urol 113:762, 1975.

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socio-economic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

Before prescribing, please consult complete product information, a summary of which follows:
Each Beroeca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha toeopheryl acetate), 500 mg vitamin C (aseorbie aeid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niaeinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenie acid (as ealeium pantothenate), 0.8 mg folie aeid, 50 mcg vitamin B_{12} (eyanoeobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg ehromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as euprie oxide), 22.5 mg zine (as zinc oxide).

Indications: Prophylaetie or therapeutie nutritional supplementation in physiologically stressful eonditions, ineluding eonditions eausing depletion, or redueed absorption or bioavailability of essential vitamins and minerals; eertain eonditions resulting from severe B-vitamin or aseorbie aeid defieieney; or eonditions resulting in inereased needs for essential vitamins and minerals.
Contraindications: Hypersensitivity to any eomponent.
Warnings: Not for pernieious anemia or other megaloblastic anemias where vitamin B_{12} is defieient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficieney who reeeive supplemental folie aeid and who are inadequately treated with B_{12}.
Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnaney, supplementation with vitamin D and ealeium may be required. Not intended for treatment of severe speeifie defieieneies. *Information for the Patient:* Toxie reaetions have been reported with injudieious use of eertain vitamins and minerals. Urge patients to follow specifie dosage instruetions. Keep out of reaeh of ehildren. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily ean deerease the effieaey of levodopa in the treatment of parkinsonism. Not reeommended for patients undergoing sueh therapy.
Adverse Reactions: Adverse reaetions have been reported with speeifie vitamins and

5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]

minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

How Supplied: Golden yellow, capsule-shaped tablets—bottles of 100.

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Nutley, New Jersey 07110

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A balanced formula for prophylactic or therapeutic nutritional supplementation.

Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

Berocca Plus, highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

candidates for

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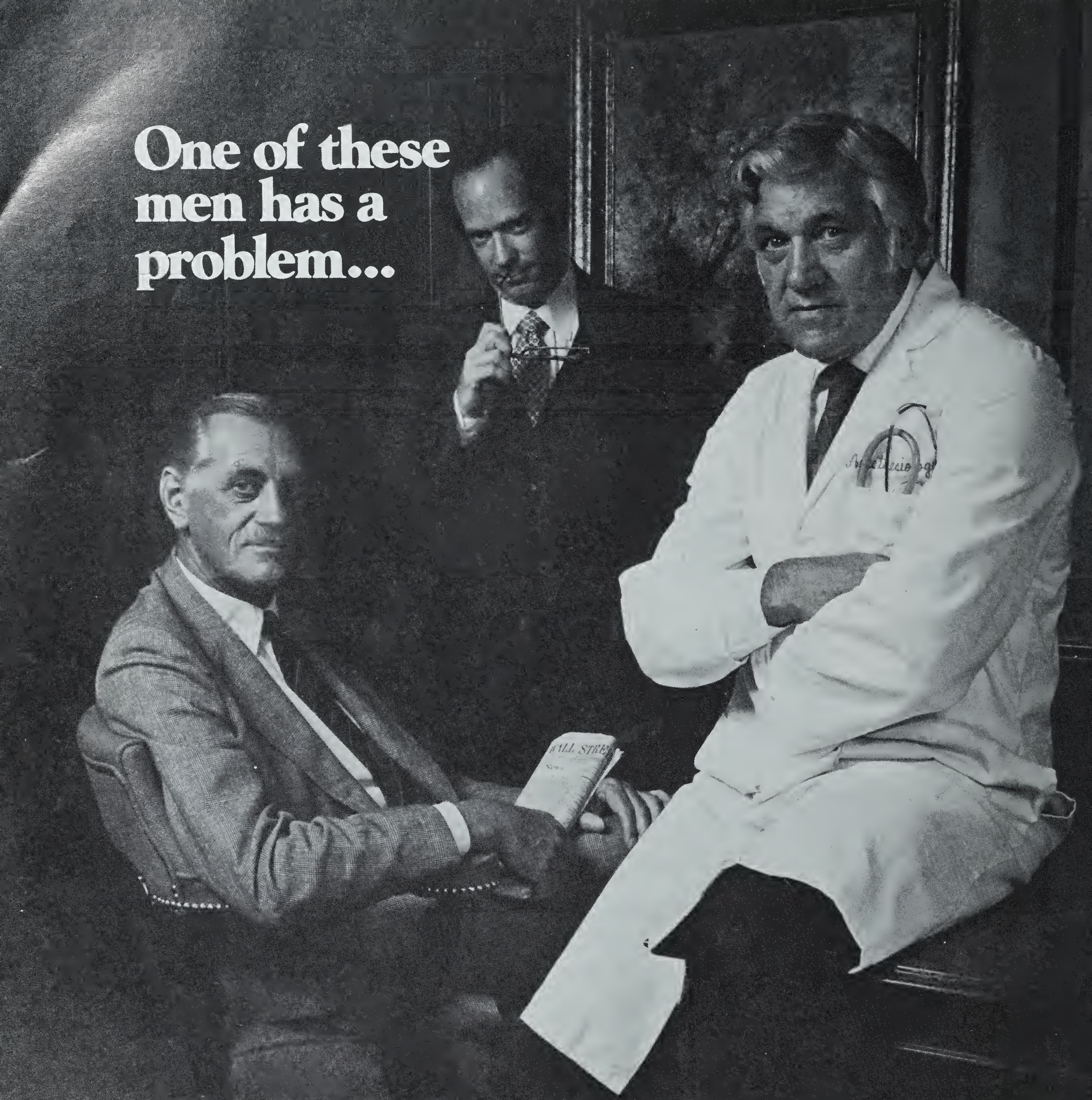
THE MULTIVITAMIN/MINERAL FORMULATION

One of these men has a problem...



and so do his family and colleagues.

There are special considerations in the treatment of professionals and executives who are impaired through dependency on drugs or alcohol: not because the patient or his addiction is different from others, but because of the strict sanctions imposed by the public and professional communities.

The A & D Center specializes in the treatment of the professional or executive who is chemically dependent. Treatment at the Center is designed to provide complete medical and counseling services, with care, dignity, and confidentiality for the patient. Family care and aftercare are emphasized, and specific plans are made for the re-entry process.

The A & D Center, located at the modern, 162-bed Doctors Hospital in Jackson, offers a 96-hour evaluation program, with the total inpatient treatment program extending for thirty days. For further information on the A & D Center, contact:

A&D Center

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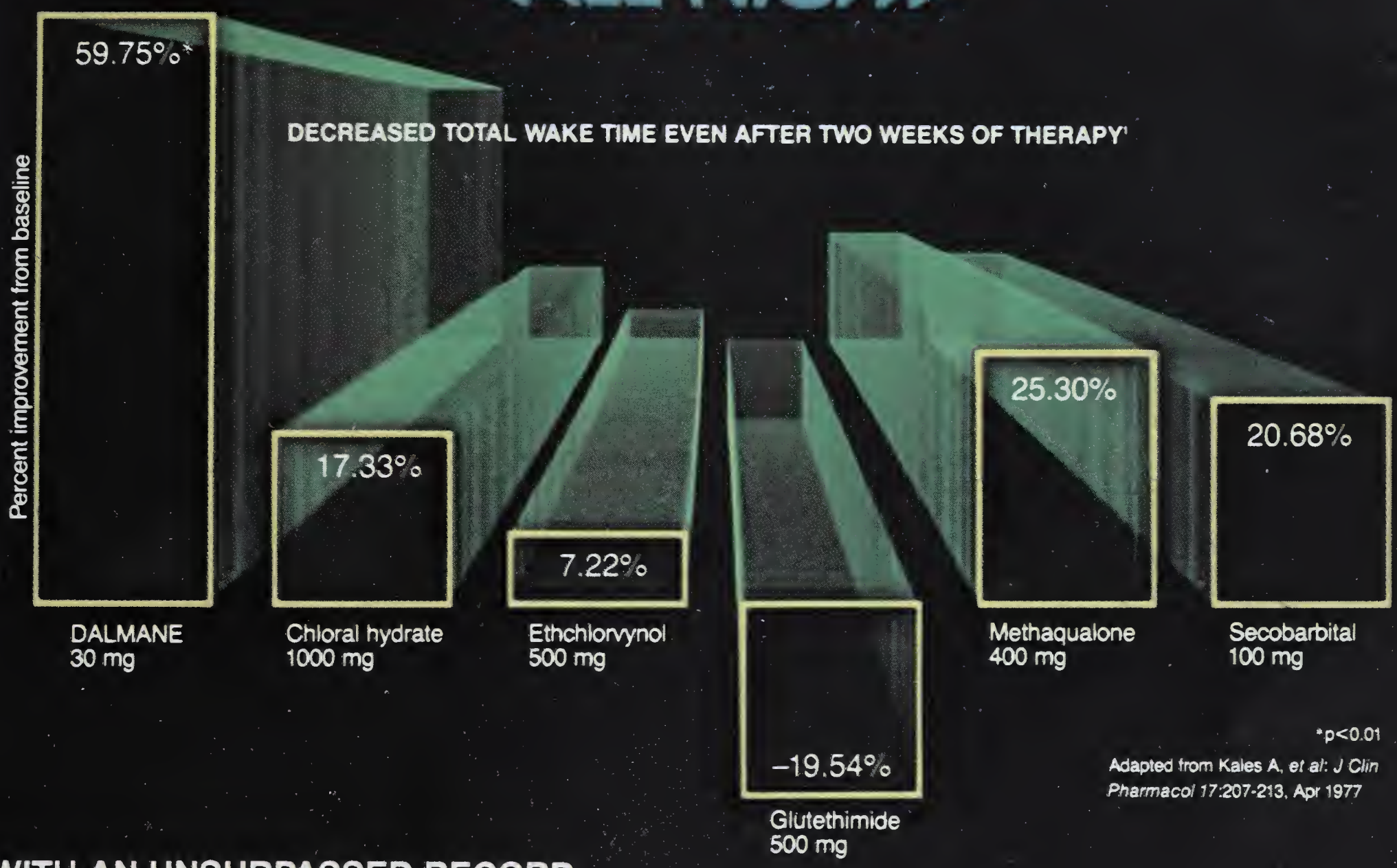

WITH AN UNSURPASSED RECORD OF EFFICACY AND SAFETY

The efficacy of Dalmane (flurazepam HCl/Roche) has been documented in 185 studies involving 9141 patients suffering from one or more of the three major forms of insomnia–difficulty falling asleep, staying asleep and sleeping long enough.[2]

Relative safety was demonstrated in a large study of 2542 hospitalized medical patients. Only 3.1% of these patients reported adverse reactions–predominantly unwanted residual drowsiness. None of the reactions were considered serious by attending physicians.[3]

FOR SLEEP WITHIN 17 MINUTES[2] AND NO WORSENING OF SLEEP ON DISCONTINUATION

Rapid sleep induction, within 17 minutes on average, sets the stage for insomnia relief. And, after discontinuation of Dalmane for periods ranging up to 14 nights, no worsening of sleep compared with baseline was observed.[4]

Should insomnia recur, the patient may require guidance in setting up a regular sleep program to help provide the optimum environment for the onset of natural sleep. If hypnotic therapy is required, it should be given for the shortest time at the lowest effective dose to achieve the desired goal.

Consider other medications the patient may be taking (including alcoholic beverages) and be aware of possible drug interactions. Please note that patients should be treated for underlying physical or psychological factors before therapy with a sleep medication is undertaken.

DALMANE® Ⓒ IV

flurazepam HCl/Roche

THE STANDARD OF HYPNOTIC EFFICACY FROM THE LEADER IN SLEEP RESEARCH

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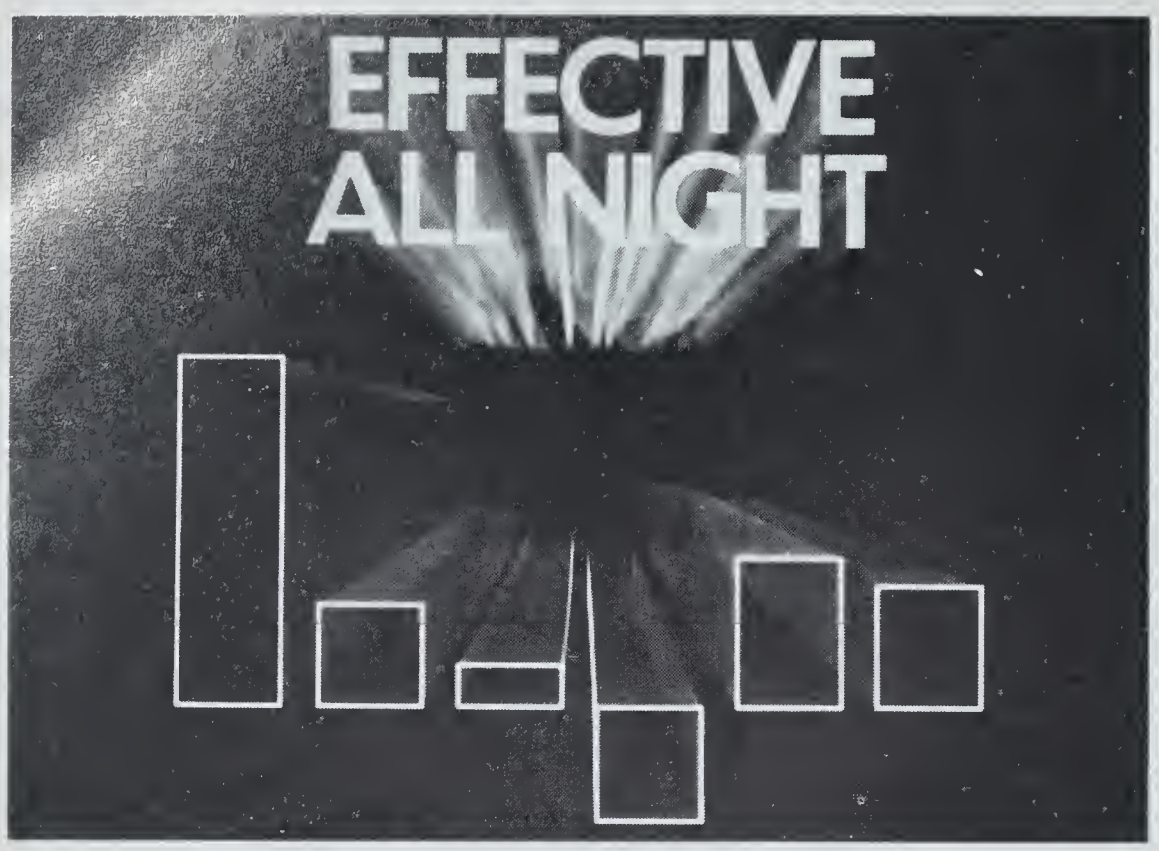
Please see reverse side for a summary of product information.



SLEEP-SPECIFIC
DALMANE® ℂIV
flurazepam HCl/Roche

One 15-mg capsule *h.s.*–recommended initial dosage for elderly or debilitated patients.
One 30-mg capsule *h.s.*–usual adult dosage
(15 mg may suffice in some patients).

THE STANDARD FOR HYPNOTIC EFFICACY WITH IMPORTANT ADDED BENEFITS

- Well tolerated[2]
- No chemical interference with many commonly ordered laboratory tests, including triglycerides, uric acid, glucose, SGOT, alkaline phosphatase and total protein[5,6] (See adverse reactions section of complete product information.)
- Compatible with chronic warfarin therapy; no unacceptable fluctuation in prothrombin time reported[7,8]

UNLIKE NONSPECIFIC MEDICATIONS USED FOR SLEEP

Tricyclic antidepressants

–which are *not* sleep specific,[9] yet are sometimes used in nondepressed patients for sleep

–which can cause transient insomnia in the elderly[10]

–which can require careful monitoring in cardiovascular patients[10]

–which have strong anticholinergic effects[10]

Antihistamines

–which are *not* reliable sleep-inducing agents[11]

–which may produce stimulation instead[11]

–which have anticholinergic effects[11]

Major tranquilizers

–whose side effects may be troublesome for nonpsychotic patients[12]

–where tolerance for sedation appears rapidly[12]

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.[4]

References: 1. Kales A, *et al*: *J Clin Pharmacol 17*:207-213, Apr 1977 **2.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977 **4.** Kales A, *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975 **5.** Moore JD, Weissman L: *J Clin Pharmacol 16*:241-244, May-Jun 1976 **6.** Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **7.** Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, pp. 641-646 **8.** Warfarin Study: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **9.** Baldessarini RJ: Drugs and the treatment of psychiatric disorders, chap. 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co Inc., 1980, pp. 391-447 **10.** Cole JO, Davis JM: Antidepressant drugs, chap. 31.2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1941-1956 **11.** Douglas WW: Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap. 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co Inc., 1980, pp. 609-646 **12.** Davis JM, Cole JO: Antipsychotic drugs, chap 31.1, in *Comprehensive Textbook of Psychiatry/II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.*g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.*g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
Adults: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

ROCHE®

ROCHE PRODUCTS INC.
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Executive Director

continued from page 4

"In fact, many people think they should, not because of any hostility toward them, but, on the contrary, because of a particular regard for them. The truth is, society still views medicine not just as a vocation but a calling. We are almost offended when a member of the healing ministry asks for cash in exchange for relieving pain. We react much as we would to a priest who sent a bill for performing last rites. Material compensation seems alien to the very nature of the commitment and objective of medicine. . . ."

It seems to me, in all the comments I have heard from the general public, that Dr. Rosenfeld has touched the crux of the matter. Even though, as he says, this idealized view of the medical profession never was and is not now the view of the profession itself, the public attachment to the myth is a tenacious one.

People complain, but only perfunctorily, about the high cost of food, automobiles, housing, everything they have to buy. But they are really outraged beyond rational dissuasion when the restoration of health is equally expensive.

That attitude is a riddle that may never be solved, but it is fundamental to the PR problem the medical profession has with the great mass of public opinion, as Dr. Feldman discovered to his great dismay. How to modify this distorted notion is something the profession has failed to accomplish. It may well be a problem without a solution.

S. Lon Conner

Members of the Consensus Development Panel

continued from page 21

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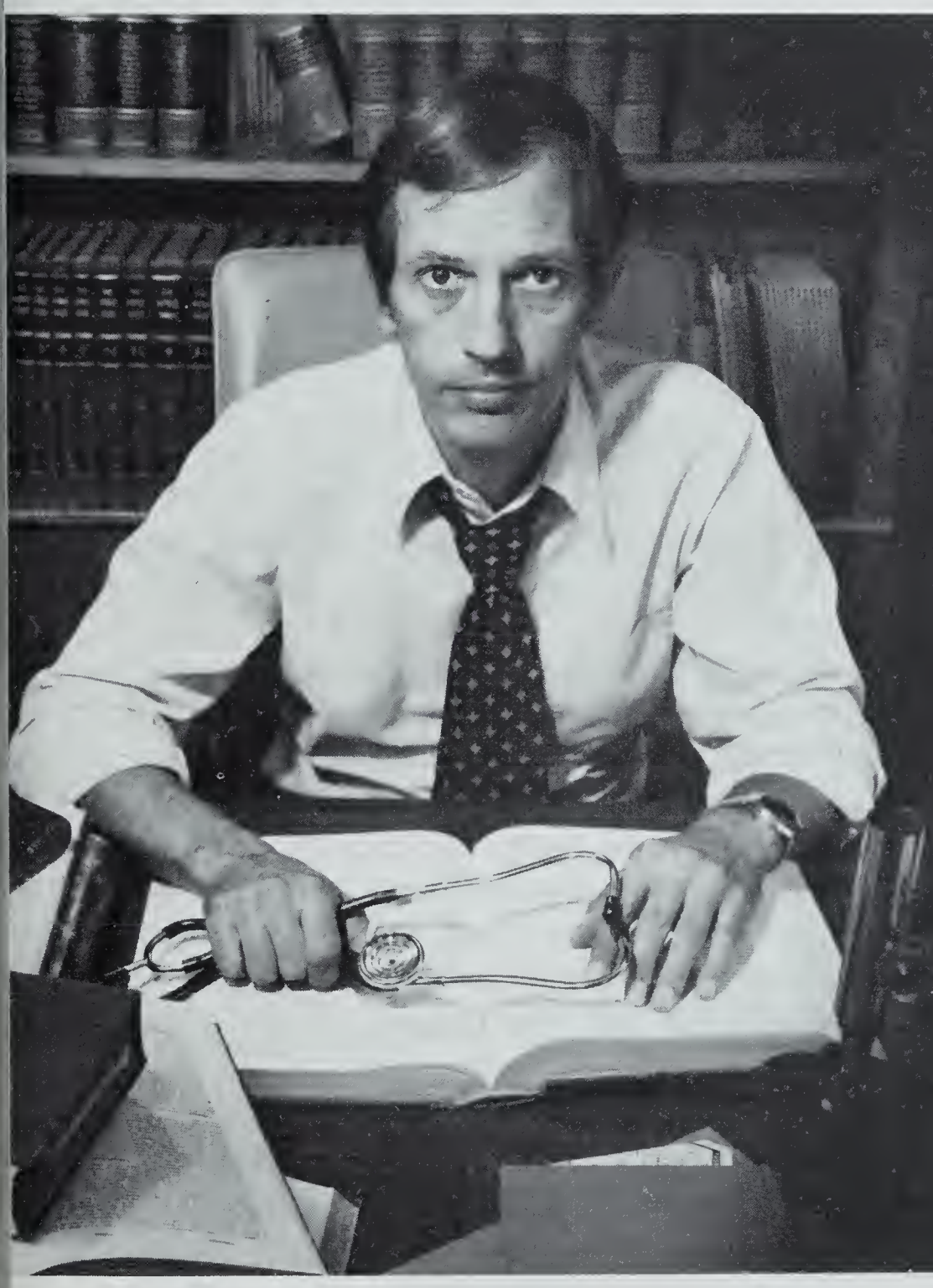

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Diagnosing this disease is difficult.

If you've found any of these problems . . .

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☑ **Sleep Disturbances**
☑ **Depression**

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PRESIDENT'S PAGE

You and Me; And GMENAC Makes Three

J. Kendall Black, Jr., M.D.
President

The recent report by GMENAC, published after months of study and analysis, predicts a surplus of physicians in this decade. A recent article in our own JOURNAL also predicts such a surplus for the state of Alabama. In fact, all recent reports of which I'm aware, agree that there will be a surplus; they merely differ with regard to the numbers. With over 120,000 individuals in medical schools and post-graduate training program, it is easy to visualize a significant oversupply of physicians.

Furthermore, with the decline of the birth rate there will be a slowing of the population increases in spite of increases in longevity. Some studies indicate that, if the Medicare demands are eliminated, there has been almost a flat curve in terms of demand for health care. Added to these factors, an increase in foreign medical graduates (whether U. S. or foreign born) will produce an ever increasing trend toward physician over-supply.

Higher unemployment, inflation, government budgetary restraints and changes in health care financing mechanisms will produce increased hardships for all physicians. An increase in the rural population of the country combined with the increasing actions of industry toward cost containment will result in added pressures on the physician population.

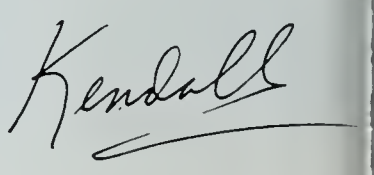
As economic changes begin to reach all elements of health care system, there will be changes in actions of hospitals, nursing homes, and allied health professionals. Such actions may well result in changes in relationships within the system. Traditional partnerships may be re-arranged and previous adversaries may become partners.

The implications for physicians are many. The laws of supply and demand suggest there will be an increasing redistribution of the physician population. As hospitals feel the increasing economic pinch there will be more attempts to attract physicians to the individual hospital's sphere of influence. Alternative types of practice will increase and medical entrepreneurs may well proliferate.

These activities, when combined with a physician surplus, may not result in health care responding to the ordinary economic laws with a resultant lowering or flattening of the price curve. On the contrary, I suspect there will be an ever increasing upward spiral. Such a response could be a disaster. Government would press for even more regulation and a major alterations in financing mechanisms would probably be legislated. Industry would be attracted to alternative types of practice as well as an increasing reliance on non-physician practitioners. All these elements would produce progressive and adverse effects on our present freedoms of practice.

In responding to, countering and preventing these potential disasters, yet assisting in the desirable changes, a strong central association is absolutely necessary at the state and national levels. As individuals we have neither the expertise nor the clout to make the necessary changes. United by our association we can be represented at all levels. Such representation is necessary now and vital for the future. We must continue to participate. Failure to do so will be destructive to our profession.

J. KENDALL BLACK, JR., M.D.
President



Delilah Strikes Again!

Mrs. Rufus E. Lee, Jr.
President, A-MASA

If there is righteousness in the heart,
There will be beauty in the character.
If there be beauty in the character,
There will be harmony in the home.
If there is harmony in the home,
There will be order in the nation.
When there is order in the nation,
There will be peace in the world.
– Author Unknown

As the deadline for my next article approaches, I am always in a stew about what subject will interest the doctors from the Auxiliary's point of view. A physician, who is a close friend, suggested *Medical Divorces*. This is an area the Auxiliary has worked on for several years through the Stress in the Medical Marriages and Worry Clinics.

Before researching the subject I was afraid it may be much too depressing to write about. Quite the contrary! There has certainly been an increase in divorce across the nation with one in every three marriages ending in divorce. However, according to an article in *The Journal of Clinical Psychiatry,* March, 1979, by Dr. Micheal Garvey and Dr. Vicente B. Tuason, the divorce rate of physicians is 8.8%, which is considerably lower than the national average.

Dr. Malcolm Freeman, Professor of obstetrics and gynecology at Emory University, reported Nov. 29, 1981, that only one in ten physician marriages end in divorce. There were several reasons attributed to these statistics: 1. the higher the education the lower the divorce rate, 2. physicians marry later than do other professionals, 3. fear of public image being injured, and 4. physicians usually marry women who are classified as extroverts. (The physicians who were married to extroverts rated their marriages better than those married to introverts.)

When divorces do occur in medical families, the largest number occur at the peak of the medical career rather than the outset of their practice.

This information was both enlightening and encouraging, especially since there has been so much publicity about our poor medical marriages; such as the article printed in *McCalls* entitled, ''Never Marry a Doctor.'' In essence, it accused the physicians of being poor husbands, poor fathers, absent companions, and ''about as useless in bed as an electric blanket with the power turned off.'' The Delilah of the press strikes again!

Divorces are generally higher for persons in occupations with irregular hours, absent from home at night, and frequent unchaperoned contact with members of the opposite sex. Physicians certainly fit this profile so other factors must contribute to our success.

The University of Nebraska made a study of couples who considered themselves happily married. Most of the guidelines they found were facts we already know but it's beneficial to review them occasionally. Spending some quality time together is certainly a top priority. A recital, ballgame, or social function is not a good substitute. There must be time to establish good communication patterns and to show love and appreciation. An extremely important point the survey brought out was ''happy families tend to be religious.'' Sometimes we forget to thank God for our special families.

We can have a good marriage when we take the time to communicate and appreciate each other, to pray for and with each other, to attack each crisis in a positive manner, and always remember to spend some time laughing. William Thackeray said, ''A good laugh is sunshine in a house.''

''The perfect marriage is a uniting of three persons — a man, a woman, and the Lord.'' — Author Unknown.

Happy Valentines Day!

Mary Julia Lee

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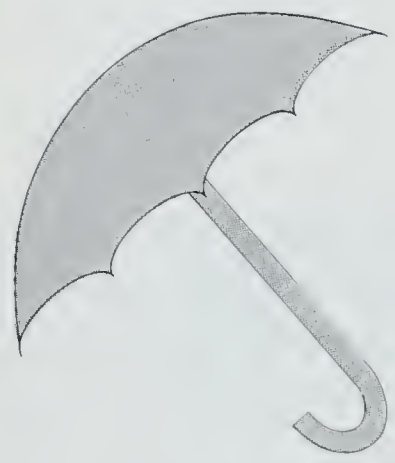

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Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General*: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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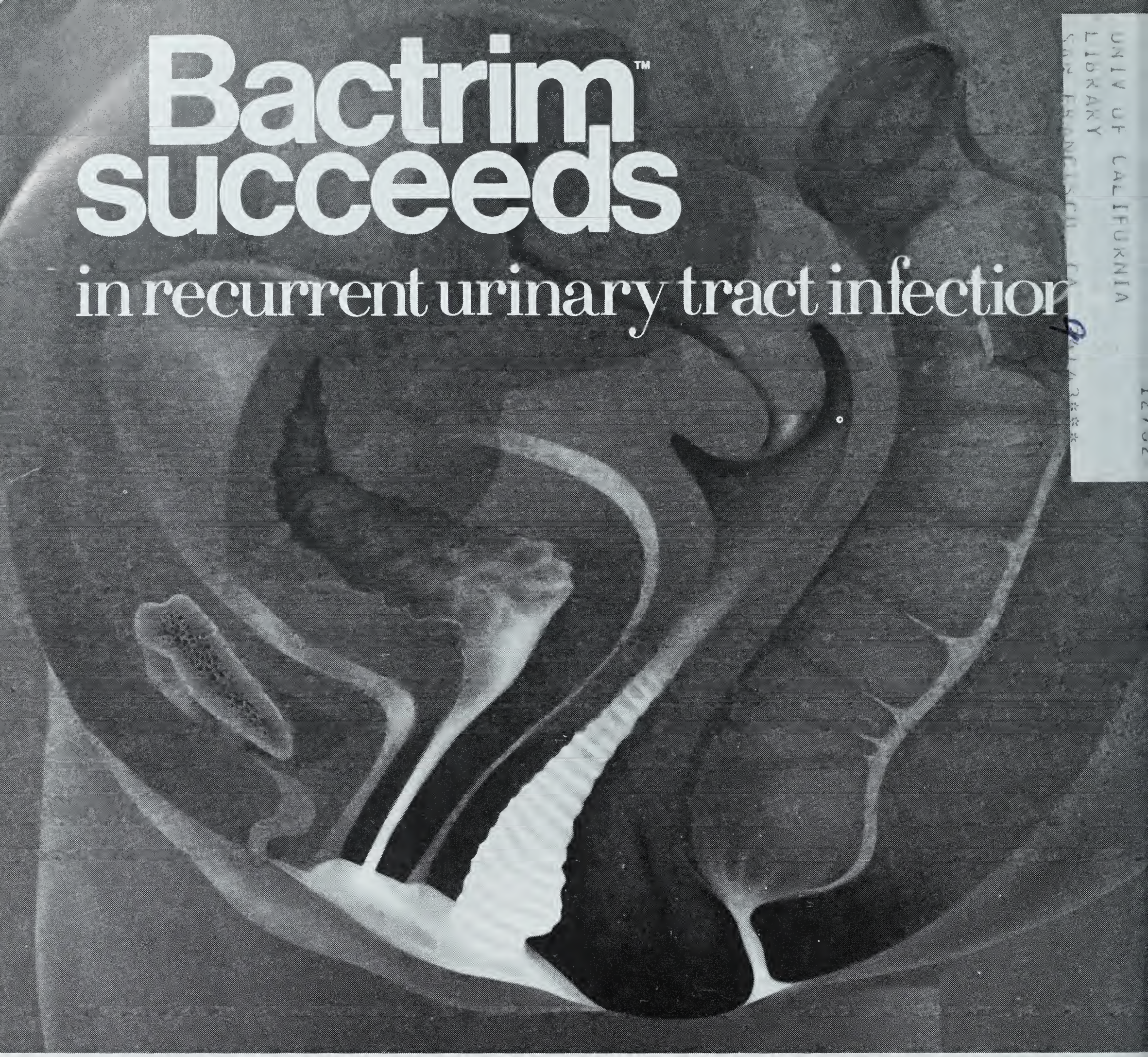
Bactrim™ succeeds

in recurrent urinary tract infection



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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980..**2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS

160 mg trimethoprim and 800 mg sulfamethoxazole

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maximizes results with B.I.D. convenience

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* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

VOL. 51, NO. 9, MARCH, 1982

JOURNAL

of the Medical Association of the State of Alabama

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"Somebody Has to Do It" — page 8

THE PATIENT THINKS HE HAS HEART TROUBLE...

...YOU KNOW IT'S REALLY ANXIETY SYMPTOMS

His presenting symptoms: palpitations, chest pain, chronic exhaustion and occasional difficulties in breathing. Good reason for concern. A complete workup uncovers no organic dysfunction, but it *does* reveal excessively high levels of anxiety and apprehension.

For rapid relief you prescribe Valium (diazepam/Roche)

At times like this, Valium (diazepam/Roche) can be a potent therapeutic ally. It works promptly. Within just a few hours, the patient begins to feel calmer. And in a few days, anxiety relief not only becomes more pronounced but a noticeable reduction in anxiety-generated somatic symptoms also occurs.

Equally important, Valium is generally well tolerated. Side reactions more serious than drowsiness, ataxia and fatigue are rare. Patients should, of course, be cautioned against driving or drinking alcohol while on Valium therapy. Periodic reassessment of the need for antianxiety medication should also be performed.

VALIUM® (IV)

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

BECAUSE YOU'RE CONVINCED THE PATIENT NEEDS IT

ROCHE®

Please see summary of product information on the following page.

VALIUM®(diazepam/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation. slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults.* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
How Supplied: For oral administration, Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500;* Prescription Paks of 50, available in trays of 10.* Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25,† and in boxes containing 10 strips of 10.†

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Physician, Heal Thyself

This Month's Cover

MASA Secretary-Treasurer William L. Smith, M.D., is a man of many talents. Active in such medical work as rehabilitation and charity clinics — in addition to his solo GP practice — he is also, by turns, teacher of seamanship and navigation; parliamentary law expert; stained glass artisan; archer; authority on mushrooms; and professor of things in general. Holding a sectant, he points to a navigational fix on the chart of Mobile Bay. Beneath are, left, a polaris, or dumb compass, for terrestrial sightings, and a special radio tuned to the National Bureau of Standards split-second time check, WWV. Story, page 8.

PRESIDENT'S PAGE

J. Kendall Black, Jr., M.D.
President

The Velvet Glove — And What Kind of Fist Within?

The velvet glove worn over a mailed fist has long been the symbol of controlled power — gentle, yet at the same time strong and firm. Teddy Roosevelt enunciated the principle into more common terms when he said, "Speak softly but carry a big stick."

Physicians, like most Americans, have in recent years seemed content to show just the velvet glove and just the soft voice. The hand within the glove has been carefully covered and held open palm facing outward. The big stick has been hidden away in the cabinet gathering dust and cobwebs.

As a result, special interest groups have proliferated and have attempted to wrest control of health care issues from the medical profession and its organizations. To a certain extent, they have succeeded but to an even greater extent, they have failed, largely due to the vast storehouse of respect and confidence that the American people hold for our profession.

We physicians have been content to sit back and try to make do even in the face of ever increasing and more onerous burdens of regulation. In spite of everything, we as independent practitioners have continually strived to deliver quality health care in an accessible manner as demanded by the American people.

The last election brought an administration intent upon making changes in our government. Indeed, Mr. Reagan is continuing to strive to diminish the burden of regulation that we as American people face. However, the shrill cries and strident voices of the special intere groups continue to berate us. Medicine is a cottag industry; the last of the mom & pop stores. It neec more competition. We spend too much money o health care.

Phooey! It's time folks remembered that it's th small businesses (the cottage industries) of Americ that have been the most innovative and the most com petitive in the history of this country. It's time the realized that we doctors are among the most competi tive people in the world. What's wrong with spendin 10% of the Gross National Product on health care?

What's wrong with the American people and th American physicians maintaining their freedom c choice regarding both from whom they seek care and t whom they give care? If we aren't careful, all the nev laws about pro-competition will merely be a new set o regulators with a new set of regulations perhaps mor burdensome than before.

Our continued lack of participation is a luxury w can no longer afford for we all have a great deal to lose As funds for education are diminished, the student wil see changes in his medical education; the resident in hi training programs. The academician will have less tim and less funds available for his research. The youn physician will find it more difficult to find a comfort able area in which to practice and live.

continued on page 5

Pfizer Laboratories
Announces

THE FIRST ORAL CALCIUM CHANNEL BLOCKER FOR THE MANAGEMENT OF ANGINA PECTORIS

NEW

PROCARDIA®

(NIFEDIPINE) *Capsules 10 mg*

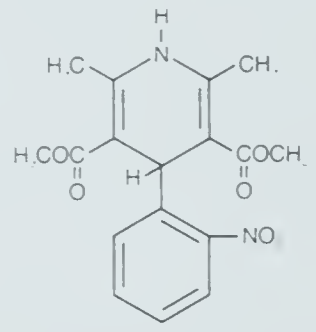
Please see PROCARDIA® *prescribing information on next page.*

PROCARDIA® CAPSULES

For Oral Use

Nifedipine

DESCRIPTION: PROCARDIA (nifedipine) is an antianginal drug belonging to a new class of pharmacological agents, the calcium channel blockers. Nifedipine is 3,5-pyridinedicarboxylic acid, 1,4-dihydro-2,6-dimethyl-4-(2-nitrophenyl)-, dimethyl ester, $C_{17}H_{18}N_2O_6$, and has the structural formula:



Nifedipine is a yellow crystalline substance, practically insoluble in water but soluble in ethanol. It has a molecular weight of 346.3. PROCARDIA CAPSULES are formulated as soft gelatin capsules for oral administration each containing 10 mg nifedipine.

CLINICAL PHARMACOLOGY: PROCARDIA (nifedipine) is a calcium ion influx inhibitor (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac muscle and smooth muscle. The contractile processes of cardiac muscle and vascular smooth muscle are dependent upon the movement of extracellular calcium ions into these cells through specific ion channels. PROCARDIA selectively inhibits calcium ion influx across the cell membrane of cardiac muscle and vascular smooth muscle without changing serum calcium concentrations.

Mechanism of Action: The precise means by which this inhibition relieves angina has not been fully determined, but includes at least the following two mechanisms:

1) Relaxation and prevention of coronary artery spasm: PROCARDIA dilates the main coronary arteries and coronary arterioles, both in normal and ischemic regions, and is a potent inhibitor of coronary artery spasm, whether spontaneous or ergonovine-induced. This property increases myocardial oxygen delivery in patients with coronary artery spasm, and is responsible for the effectiveness of PROCARDIA in vasospastic (Prinzmetal's or variant) angina. Whether this effect plays any role in classical angina is not clear, but studies of exercise tolerance have not shown an increase in the maximum exercise rate-pressure product, a widely accepted measure of oxygen utilization. This suggests that, in general, relief of spasm or dilation of coronary arteries is not an important factor in classical angina.

2) Reduction of oxygen utilization: PROCARDIA regularly reduces arterial pressure at rest and at a given level of exercise by dilating peripheral arterioles and reducing the total peripheral resistance (afterload) against which the heart works. This unloading of the heart reduces myocardial energy consumption and oxygen requirements and probably accounts for the effectiveness of PROCARDIA in chronic stable angina.

Pharmacokinetics and Metabolism: PROCARDIA is rapidly and fully absorbed after oral administration. The drug is detectable in serum 10 minutes after oral administration, and peak blood levels occur in approximately 30 minutes. It is highly bound by serum proteins. PROCARDIA is extensively converted to inactive metabolites and approximately 80% of PROCARDIA and metabolites are eliminated via the kidneys. The half-life of nifedipine in plasma is approximately two hours. There is no information on the effects of renal or hepatic impairment on excretion or metabolism of PROCARDIA.

Hemodynamics: Like other slow channel blockers, PROCARDIA exerts a negative inotropic effect on isolated myocardial tissue. This is rarely, if ever, seen in intact animals or man, probably because of reflex responses to its vasodilating effects. In man, PROCARDIA causes decreased peripheral vascular resistance and a fall in systolic and diastolic pressure, usually modest (5–10 mm Hg systolic), but sometimes larger. There is usually a small increase in heart rate, a reflex response to vasodilation. Measurements of cardiac function in patients with normal ventricular function have generally found a small increase in cardiac index without major effects on ejection fraction, left ventricular end diastolic pressure (LVEDP) or volume (LVEDV). In patients with impaired ventricular function, most acute studies have shown some increase in ejection fraction and reduction in left ventricular filling pressure.

Electrophysiologic Effects: Although, like other members of its class, PROCARDIA decreases sinoatrial node function and atrioventricular conduction in isolated myocardial preparations, such effects have not been seen in studies in intact animals or in man. In formal electrophysiologic studies, predominantly in patients with normal conduction systems, PROCARDIA has had no tendency to prolong atrioventricular conduction, prolong sinus node recovery time, or slow sinus rate.

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure since severe hypotension can occur from the combined effects of the drugs. See Warnings.

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Increased Angina/Beta Blocker Withdrawal: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of PROCARDIA would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. See Warnings.

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, ca should be taken to differentiate this peripheral edema from the effects of increasing left ventricul dysfunction.

Drug interactions: Beta-adrenergic blocking agents: See Indications and Warnings. Experienc in over 1400 patients in a non-comparative clinical trial has shown that concomitant administratic of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occ sional literature reports suggesting that the combination may increase the likelihood of congestiv heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there hav been no controlled studies to evaluate the antianginal effectiveness of this combination.

Carcinogenesis, mutagenesis, impairment of fertility: Nifedipine was administered orally to ra for two years and was not shown to be carcinogenic. When given to rats prior to matin nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommende human dose. In vivo mutagenicity studies were negative.

Pregnancy: Pregnancy category C. Nifedipine has been shown to be teratogenic in rats whe given in doses 30 times the maximum recommended human dose. Nifedipine was embryotox (increased fetal resorptions, decreased fetal weight, increased stunted forms, increased fet deaths, decreased neonatal survival) in rats, mice and rabbits at doses of from 3 to 10 times th maximum recommended human dose. In pregnant monkeys, doses 2/3 and twice the maximu recommended human dose resulted in small placentas and underdeveloped chorionic villi. I rats, doses three times the maximum human dose and higher caused prolongation of pregnanc There are no adequate and well-controlled studies in pregnant women. PROCARDIA should b used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

ADVERSE REACTIONS: In multiple-dose U.S. and foreign-controlled studies in which advers reactions were reported spontaneously, adverse effects were frequent but generally not seriou and rarely required discontinuation of therapy or dosage adjustment. Most were expected conse quences of the vasodilator effects of PROCARDIA.

Adverse Effect	PROCARDIA (%) (N = 226)	Placebo (%) (N = 23
Dizziness, light-headedness, giddiness	27	15
Flushing, heat sensation	25	8
Headache	23	20
Weakness	12	10
Nausea, heartburn	11	8
Muscle cramps, tremor	8	3
Peripheral edema	7	1
Nervousness, mood changes	7	4
Palpitation	7	5
Dyspnea, cough, wheezing	6	3
Nasal congestion, sore throat	6	8

There is also a large uncontrolled experience in over 2100 patients in the United States. Most the patients had vasospastic or resistant angina pectoris, and about half had concomitant trea ment with beta-adrenergic blocking agents. The most common adverse events were the sam ones seen in the controlled trials, with dizziness or light-headedness, peripheral edema, nausea weakness, headache and flushing each occurring in about 10% of patients, transient hypotensio in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recu with reduction in the dose of PROCARDIA or concomitant antianginal medication. Very rarely, ir troduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly du to associated hypotension.

Several of these side effects appear to be dose related. Peripheral edema occurred in abou one in 25 patients at doses less than 60 mg per day and in about one patient in eight at 120 mg pe day or more. Transient hypotension, generally of mild to moderate severity and seldom requirin discontinuation of therapy, occurred in one of 50 patients at less than 60 mg per day and in one 20 patients at 120 mg per day or more.

In addition, 2% or fewer of patients reported the following: Respiratory: Nasal and ches congestion, shortness of breath. Gastrointestinal: Diarrhea, constipation, cramps, flatulence Musculoskeletal: Inflammation, joint stiffness, muscle cramps. CNS: Shakiness, nervousness, jit teriness, sleep disturbances, blurred vision, difficulties in balance. Other: Dermatitis, pruritus, ur ticaria, fever, sweating, chills, sexual difficulties.

In addition, more serious adverse events were observed, not readily distinguishable from th natural history of the disease in these patients. It remains possible, however, that some or many c these events were drug related. Myocardial infarction occurred in about 4% of patients an congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conductio disturbances each occurred in fewer than 0.5% of patients.

In a subgroup of over 1000 patients receiving PROCARDIA with concomitant beta blocker ther apy, the pattern and incidence of adverse experiences was not different from that of the entir group of PROCARDIA treated patients (see Precautions).

In a subgroup of patients with a diagnosis of congestive heart failure as well as angina, dizzi ness or light-headedness, peripheral edema, headache or flushing each occurred in one in eigh patients. Hypotension occurred in about one in 20 patients. Syncope occurred in approximatel one patient in 250. Myocardial infarction or symptoms of congestive heart failure each occurre in about one patient in 15. Atrial or ventricular dysrhythmias each occurred in about one patien in 150.

Laboratory tests: Rare, mild to moderate, transient elevations of enzymes such as alkalin phosphatase, CK, LDH, SGOT, and SGPT have been noted, and a single incident of significantl elevated transaminases and alkaline phosphatase was seen in a patient with a history of gal bladder disease after about eleven months of nifedipine therapy. The relationship t PROCARDIA therapy is uncertain. These laboratory abnormalities have already been associate with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reporte twice in the extensive world literature.

OVERDOSAGE: Although there is no well documented experience with PROCARDIA overdos age, available data suggest that gross overdosage could result in excessive peripheral vasodila tion with subsequent marked and probably prolonged systemic hypotension. Clinically significan hypotension due to PROCARDIA overdosage calls for active cardiovascular support includin monitoring of cardiac and respiratory function, elevation of extremities, and attention to circulatin fluid volume and urine output. A vasoconstrictor (such as norepinephrine) may be helpful in re storing vascular tone and blood pressure, provided that there is no contraindication to its use Clearance of PROCARDIA would be expected to be prolonged in patients with impaired live function. Since PROCARDIA is highly protein-bound, dialysis is not likely to be of benefit.

DOSAGE AND ADMINISTRATION: The dosage of PROCARDIA needed to suppress angina and that can be tolerated by the patient must be established by titration. Excessive doses can result in hypotension.

The starting dose is one 10 mg capsule, swallowed whole, 3 times/day. The usual effective dose range is 10–20 mg three times daily. Some patients, especially those with evidence of coronary artery spasm, respond only to higher doses, more frequent administration, or both. In such patients, doses of 20–30 mg three or four times daily may be effective. Doses above 120 mg daily are rarely necessary. More than 180 mg per day is not recommended.

In most cases, PROCARDIA titration should proceed over a 7–14 day period so that the physician can assess the response to each dose level and monitor the blood pressure before proceeding to higher doses.

If symptoms so warrant, titration may proceed more rapidly provided that the patient is assessed frequently. Based on the patient's physical activity level, attack frequency, and sublingual nitroglycerin consumption, the dose of PROCARDIA may be increased from 10 mg t.i.d. to 20 mg t.i.d. and then to 30 mg t.i.d. over a three-day period.

In hospitalized patients under close observation, the dose may be increased in 10 mg increments over four to six-hour periods as required to control pain and arrhythmias due to ischemia. A single dose should rarely exceed 30 mg.

No "rebound effect" has been observed upon discontinuation of PROCARDIA. However, if discontinuation of PROCARDIA is necessary, sound clinical practice suggests that the dosage should be decreased gradually with close physician supervision.

Co-Administration with Other Antianginal Drugs: Sublingual nitroglycerin may be taken as required for the control of acute manifestations of angina, particularly during PROCARDIA titration. See Precautions, Drug Interactions for information on co-administration of PROCARDIA with beta blockers or long-acting nitrates.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA Capsule contains 10 mg of nifedipine. PROCARDIA Capsules are supplied in amber glass bottles of 100 capsules (NDC 0069-2600-66).

The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

Issued January 1982

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Pfizer LABORATORIES DIVISION
PFIZER INC NEW YORK N Y 10017

April in Huntsville

There will be enough extras at next month's annual ession in Huntsville to entice even those of you who ıay not have attended in recent years.

The Friday night awards banquet, for example, will ffer special music tailored to high brows and low rows alike:

During the reception preceding the banquet, the tring Quartet of Huntsville Symphony Orchestra will erform; after the awards, for those (like me) whose stes run to the familiar, there is another first: a Barber hop Chorus.

During the plenary scientific session Thursday afterpon, J. Claude Bennett, M.D., Chairman, Departent of Medicine, UAB, will speak on a subject in hich he has unchallenged expertise, ''Genetic Enneering in Its Future Role in Medicine.'' Dr. Bennett a physician/scientist with extensive training and nowledge in molecular biology in addition to his osen medical fields of rheumatology and oncology.

Following Dr. Bennett's address, the Alabama Soci- y for Gastrointestinal Endoscopy will put on a special ogram, another first, featuring experts from the Uni- rsity of South Alabama and UAB.

This program will be followed by what should be a scinating discussion of medical problems in space by ıe of NASA's astronauts.

After this on Thursday, the program gets appealingly fbeat. Jeffrey Bayer, Chairman of the University of labama/Huntsville Art Department, will speak on 'The World of Modern Sculpture,'' followed by a tour the Huntsville Art Museum. The Auxiliary is invited the lecture and tour, as well as interested physicians.

The Friday scientific sessions will be divided into ree sections:

Neurosurgery, with four knowledgeable speakers from UAB and private practice;

Pediatrics, with six speakers on subjects ranging from allergic problems of children to psychological aspects of childhood headaches;

Medicine, with six experts from the University of South Alabama and UAB.

The Jerome Cochran lecture at noon Friday will be delivered by the Washington physician who so skillfully communicated to the world the nature of President Reagan's injuries in the assassination attempt last year — Dennis S. O'Leary, M.D., Dean for Clinical Affairs, George Washington University School of Medicine. The title of his address is: ''Medical Diary of an Attempted Assassination.''

The Orientation Program, which has been moved from Thursday morning to Friday afternoon, will feature more present and former members of the Board of Censors than in recent years, with 20-minute talks ranging from the organization of Alabama Medicine to medical ethics.

Huntsville is surely one of Alabama's loveliest cities and right up at the top in hospitality. I hope you will read the complete program in MASA publications and join your fellow physicians there for a satisfying blend of science, socio-economic information, unusual entertainment, and the Saturday morning business session.

S. Lon Conner

Dr. Smith: ''Somebody Has to Do It''

William H. McDonald

Few Alabama physicians have as long a history of yeoman's service to Alabama medicine as William L. Smith, M.D. He has toiled in the vineyards all his professional life.

Dr. Smith has been Secretary-Treasurer of MASA for 21 years, secretary of the Montgomery County Society for some 30 years and editor of the JOURNAL for 20 years.

It is because of that latter capacity, Editor of the JOURNAL, that Dr. Smith has steadfastly refused to have any profile on him in the magazine. It would be unseemly, he has repeatedly said, some kind of conflict of interest.

He finally submitted to a brief sketch, which this writer has been trying to do for almost five years, if it would be based on and limited to his interest in boats, water safety and navigation *(see cover)*.

Dr. Smith, wearing one of his many hats, is an energetic teacher of these subjects, sometimes using a MASA conference room as his classroom, the walls plastered with charts and calculations.

In the course of extracting this pertinent information from him, all under protest, a few other facts were gleaned from his interesting and multi-faceted life.

William L. Smith was born and raised in Wetumpka, Elmore County, the son of a banker who had to sell the family institution during the Great Depression to prevent his depositors from losing money, as many thousands of others did all over the state and the nation. ''We lost the bank,'' Dr. Smith recalls, ''but no depositor lost a dime.''

Honorable solutions like that are in Dr. Smith's genetic heritage. He is eminently fair minded in all his dealings with fellow physicians and MASA staff. Nor does he shy from scutwork.

Asked why, for example, that for 36 years he has two mornings a week, served at charity clinics, usually providing his services gratis to an average 1,200 new patients a year, Dr. Smith says, with his usual penchan for the unsensational:

''It has to be done. They need care. If there wasn' anyone to pick up the garbage, I would pick it up. don't want to do some of the things I feel I must do, bu *somebody has to do it.''*

Those last five words are probably as complete a biography as anyone can write of Dr. Smith.

Under Hitler's Guns

Many of the physicians who served in World War I may have sought rear echelon posts well away from the perils of the front. Not Dr. Smith. Fresh out of Tulane Medical School, he joined the Army and opted for the infantry rather than to accept a duplicate set of orders received the same day for residency training in psychiatry under Army auspices at the University of Wisconsin.

Although psychiatry had been his specialty of choice at Tulane, somebody had to take care of the troops in the line. Lieutenant (later Captain and Major) Smith accepted that, as he has before and since, as a duty he would not try to escape. He marched across Europe with the 78th Infantry Division, won the Bronze Star with citations for the Battle of the Bulge, the Battle of Central Europe and the Battle of the Rhine.

Thrown into Hitler's Siegfried Line between Rotgen and Lammersdorf during that terrible winter of 1944-45 (he had observed Thanksgiving 1944 in France), Capt. Smith's 309th Infantry Regiment was sorely beset by Hitler's last real chance to defeat the Allies. Panzers, tanks, planes and paratroopers — everything the Ger-

nan war machine had — were thrown into the Battle of he Bulge.

Within a two-hour span of time, the Division chap-ain and one of Capt. Smith's fellow medical officers vere killed by sniper fire within 15 feet of him. The hysician died on Capt. Smith's aid station table. Another sniper's bullet narrowly missed Capt. Smith's ead as he threw himself into the mud (an instinctive eaction he was to repeat a year later in Montgomery, vhen he hit the sidewalk reflexively on Court Square n hearing what seemed to be that sound again).

A River Rock Office?

Dr. Smith returned to Wetumpka in 1946 only to iscover that no office space was available and that the ederal government, which still controlled all building ermits under war emergency powers, would only llow him to erect his own structure if he built it out of ndigenous materials, specifically ''rocks from the Coosa River and locally made shingles.''

This being quite impossible, as it was intended to be y a ''big, fat, cigar-smoking bureaucrat,'' he settled or backing up a Montgomery physician who was ill. Somebody had to do it. Eventually that led to pre-ious office space in the First National Bank Building, although most Montgomery physicians in those days were clustered in the Bell Building.

A decade ago, Dr. Smith moved into comfortable and spacious modern offices directly across the street from the Association building. He zips across that street many times a day, between patients, to attend to his many duties as Editor and Secretary-Treasurer, his smiling, moon face concealing the vexations he endures in private solo practice as a GP, his demanding charity work and his job as Medical Director of the Central Alabama Rehabilitation, a post he has held for 20 years.

How does he do all he does? To that frequently asked question, Dr. Smith has a pat answer: ''It has to be done.''

Ergo, it *will* be done. And if nobody else will do it, he'll do it. Such an uncomplicated approach to work is rare in an age when many Americans seem to spend a great part of their time devising schemes to prove their work should be done by someone else.

Dr. Smith is not of that generation. His private work ethic spills over into such matters as rehabilitation theory. Asked once about what he had learned from 20 years in that line of medical endeavor, Dr. Smith answered the question with a question:

Are the results of
$100 million worth of
government-funded research
on hypertension
worth reading about?

"One question I have never been able to answer is this: with all our miracles of restoring people to physical and mental self-sufficiency, how do you rehabilitate a bum?"

Dynamite Comes In Small Packages

He can be blunt and hard-hitting, traits he may have acquired in the 1930s when he was one of the smallest football players on the field. He had to be mean to survive. But he is never cruel, even to those he thinks deserve it.

Although he wouldn't want this printed, he made All-State quarterback in 1934 at Wetumpka High. Weighing 136 pounds after a full meal, William Smith got to play, he insists today, only because there weren't enough full-sized boys to have a scrimmage. In other words, somebody had to do it.

His interest in writing began in high school when he deplored the fact that Wetumpka High had no newspaper. He founded one, because somebody had to and nobody else wanted to. He became its first editor, winning an honorable mention in state competition for his very first editorial, which explained the need for a school newspaper.

At Tulane he was thinking of being a psychologist, majoring in that and philosophy, earning a BA degree instead of the BS, when the thought kept repeating itself that the only way to understand a complex human being was to understand all of him, physical and emotional. That prompted the switch to medicine and — had it not been the duty he saw in the war — a career in psychiatry. No regrets about that switch, he says.

The range and diversity of Dr. Smith's information is always astounding. Once, several years ago, I casually mentioned a weekend project I had trying to construct some kind of water chiller for my darkroom, to lower the heat of summer ground water. Dr. Smith lectured, extemporaneously, on thermocouples.

All You Need to Know

For purpose of this brief profile, I asked him to explain the meaning of a "cat rigged" sailboat. His answer, in its entirety, delivered with blinding speed and no fumbling in perhaps 30 seconds, follows:

"A cat boat has one mast that is quite well forward and carries one sail. You can have a cat boat that's 60 feet long or 6 feet long.

"The sloop, in contradistinction, has the mast further back, is fore and aft rigged, with a jib in front of the mast and a mainsail aft of the mast. It can be either Marconi-rigged, that is to say triangular, or gaff-rigged, which is quadralateral.

"Put up a second mast, shorter than the mainmast, place it in front of the rudder post, and you have a ketch.

"Put the second short mast back of the rudder post, you got a yawl.

"Put two masts of the same size, you got a schooner Put an aft mast taller than the front mast, you still got schooner. You put three masts, two equal or thre equal, that's still a schooner.

"Set your one mast almost amidships, so you can fl two sails in front of it and one aft, instead of a sloop yo have a cutter.

"These are the main configurations of small sailin vessels."

Thank you, Dr. Smith. Like the little girl who wer to the library to do a short essay on penguins only t find "more about penguins than I wanted to know," you shouldn't ask Dr. Smith a question unless you war a full answer.

Turned On At Age One

Since this biographical thumbnail was supposed t be exclusively nautical, it may be said that Dr. Smith' interest in boats began, he swears, at the age of one when he received a toy one for his first birthday. In few years, he was carving them out of scrap wood. H built his first real sailboat at age 14, only the thir sailboat on Lake Jordan in the early 1930s.

While at Tulane, he cadged a student membership i the Southern Yacht club and sailed on Lake Pontchar train.

Also at Tulane, he once again found his limite stature an advantage when the dowager of an old Nev Orleans family put him up in her otherwise off-limits to-students posh home, called him "little darling" an served him high cuisine for all his academic years as h luxuriated in a private room with a four poster bed sleeping porch and tile bath, at a time when othe students were happy to find lodging in a closet.

The story of that family, which married into Germa royalty, is "a book I ought to write one day," Dr Smith says. That being his intent, there will be n infringement here, although a sneak preview may no be inappropriate: It is a Southern Gothic tale of triumph and decay, of love and incest, of misbegotten romance and nationalist hatred, of a German sugar chemist an the Junker grandson of Bismarck, all against the back ground of Old New Orleans.

The boat interest in childhood ("Everything come from childhood," Dr. Smith is fond of saying) wa stimulated by an uncle who had graduated from Annap olis. About the same time, a parallel interest in archer developed. It was a time, during the Depression an before television, when Alabama youngsters had t provide their own entertainment. Not only did Willia Smith build his own boats, he also constructed his ow bows and arrows, having been inspired by an earl silent movie of Robin Hood, the Hentey Books an *Woodland Lore* by Ernest Thompson Seaton.

This evolved into his post-war entry in archer tournaments, his being drafted as President of th Southern Archery Association and, 20 years ago, dis

patched by that group to sit on the Board of Directors of the National Field Archery Association.

Dr. Smith really didn't have the time for all this committee work, although he loves the sport, but his bow and arrow constituents hit the right nerve when they convinced him that "somebody has to do it." There is no argument more persuasive to William L. Smith, M.D.

Dr. Smith's other talents include: designing and producing stained glass, at which he is a past master; mushroom identification, a subject on which he has written for the JOURNAL; gourmet cooking; seafood, in fact and legend; parliamentary law; gold mining in early Alabama; and so on, the list being lengthened every time you talk to him.

There is a distinct line, of course, between these avocations and the true calling Dr. Smith has in medicine. He does charity work because somebody has to do it. Boats, stained glass creation, cooking, history and folklore — all these interest him because he does NOT have to do it.

His memory for facts and even trivia constantly amazes the MASA staff. He swears he can remember everything that ever happened to him, and almost everything he has read, from his first birthday on.

I, for one, believe it.

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In 1977, when the Veterans Administration compared Step-2 regimens in 450 mild hypertensive patients, **which regimen was proven most effective?**[1]

How I Examine the Spleen

Joseph D. Sapira, M.D., Professor of Medicine

Inspection: One inspects the abdomen during inspiration to see if a mass can be noted to descend. However, even in those rare cases when one can observe a mass, one needs to determine that the mass is in fact the spleen and so must proceed to palpation.

Palpation: With the patient supine and the examiner at the patient's right, the spleen may be examined for splenomegaly by placing the right hand below the costal margin and pressing the fingers in deeply. In cases of extreme splenomegaly, the examiner may not catch the lower edge of the spleen, the palpating hand being cephalad to it. Thus a general sensation of resistance in this position requires the examiner to move his palpating hand down into the lower left quadrant, slowly inching up, so as to catch the lower edge of such an elephantine spleen.

This primary method may be improved upon by placing the examiner's left hand in the patient's left subcostovertebral area and (simultaneously with the right hand's palpation), pulling upwards with the left hand so as to provide a better definition of the spleen.

In very obese patients it may be necessary to place the left hand anteriorly to press down upon adiposity, hoping to shepherd the intervening tissue for the palpating right hand. However, when patients are so fat, rarely can I find a spleen with this trick that is not apparent to percussion (vide infra).

A second technique is to examine a patient who is placed in the modified right lateral decubitus position; modified, in that the flexed right arm supports the dependent right rib cage, throwing the left subcostal area into aerial relief. The physican stands behind the patient and palpates with the right hand anterior to th left hand which is in the posterior axillary line. This i similar to Middleton's method.[1]

A third technique is to have the patient sit in a chai while the physician leans over the patient's left shoul der from behind. The physician examines for the splee by palpating with the left hand in the patient's lef anterior axillary line, the right hand anterior and media to the left, covering the area from the left mid clavicular line laterally.

Fourthly, the patient may be placed in the pron position supporting himself on knees and elbows o knees and chest. I use the right hand to try and catch spleen tip.

A fifth method involves rotating the patient in th right lateral decubitus and palpating with the righ hand, the examiner remaining on the right side of th bed.[2-4] I have no experience with this method but doubt the specificity of this test since the same proce dure, palpating for tenderness, is used as a bedside tes for pancreatitis by the French (Guy-Mallet sign). (Sup posedly, the spleen falls away from the tail of th pancreas exposing the latter to palpation.)

It is claimed that splenic palpation may be facilitate by having the patient jump up and down 20 to 25 time prior to palpation, following which the subject stands bending slightly forward, with the examiner to hi rear.[5]

In all positions the patient should be instructed t breathe deeply so that the left hemidiaphragm wil move the spleen down into palpating range. Man patients respond with abdominal respirations. In tha case, get your hands in position first and then instruc the patient to breathe "with the chest, only."

Reprints: Dr. Joseph D. Sapira, M.D., Department of Medicine, University of South Alabama Medical Center, 2451 Fillingim Street, Mobile, Alabama 36617.

If you are not sure that you have caught a spleen tip ask the patient to report their sensations. They will often be able to report a ''catching'' sensation when their spleen hits your hand or fingers.

I have never been able to palpate a spleen in the third or fourth position that was not apparent from examination by the first or second method.

The most common cause of pseudosplenomegaly in my experience has been colonic feces (which disappear following purgation). I have not been able to prove the distinction by using the splenic notch, although a large mass is almost always the spleen.

Once you can palpate the spleen it is important to attempt to determine if it is hard or merely tense. If merely tense, the splenomegaly is acute, especially acute-resolving. If hard (''firm''), the splenomegaly is probably chronic, as in 44% of patients with Laennec's cirrhoses.[6]

Unfortunately, some palpable spleens are not pathologic, and some pathologically enlarged spleens may not be palpable.[7-10] (''Some'' means less than 5%; ''Enlarged'' is almost a metaphysical term.)[11-13] However, a palpable spleen always justifies an evaluation of the patient, except in the immediate post-partum period when extreme relaxation of the abdominal musculature permits 12% of normal spleens to be palpable.[14]

Percussion: Castell has introduced the useful technique of percussion over the lowest intercostal space in the left anterior axillary line during deep breathng.[15-16] Enlarged, but non-palpable spleens will cause a dullness of the percussion note during deep inspiration with resonance returning during expiration, as the diaphragm and spleen move back up, cephalad.

This technique is best learned upon a patient with palpable splenomegaly in whom the splenomegaly is resolving. Daily exams will determine a point when the percussion sign is still positive although the examiner can no longer palpate the spleen. Resolving splenomegaly of this type is most commonly found in infectious mononucleosis, resolving viral hepatitis and about 10% of patients with thyrotoxicosis who are undergoing ablative treatment.

Auscultation: A splenic infarct may result in an audible rub. Splenic arteriovenous aneurysms may produce murmurs.

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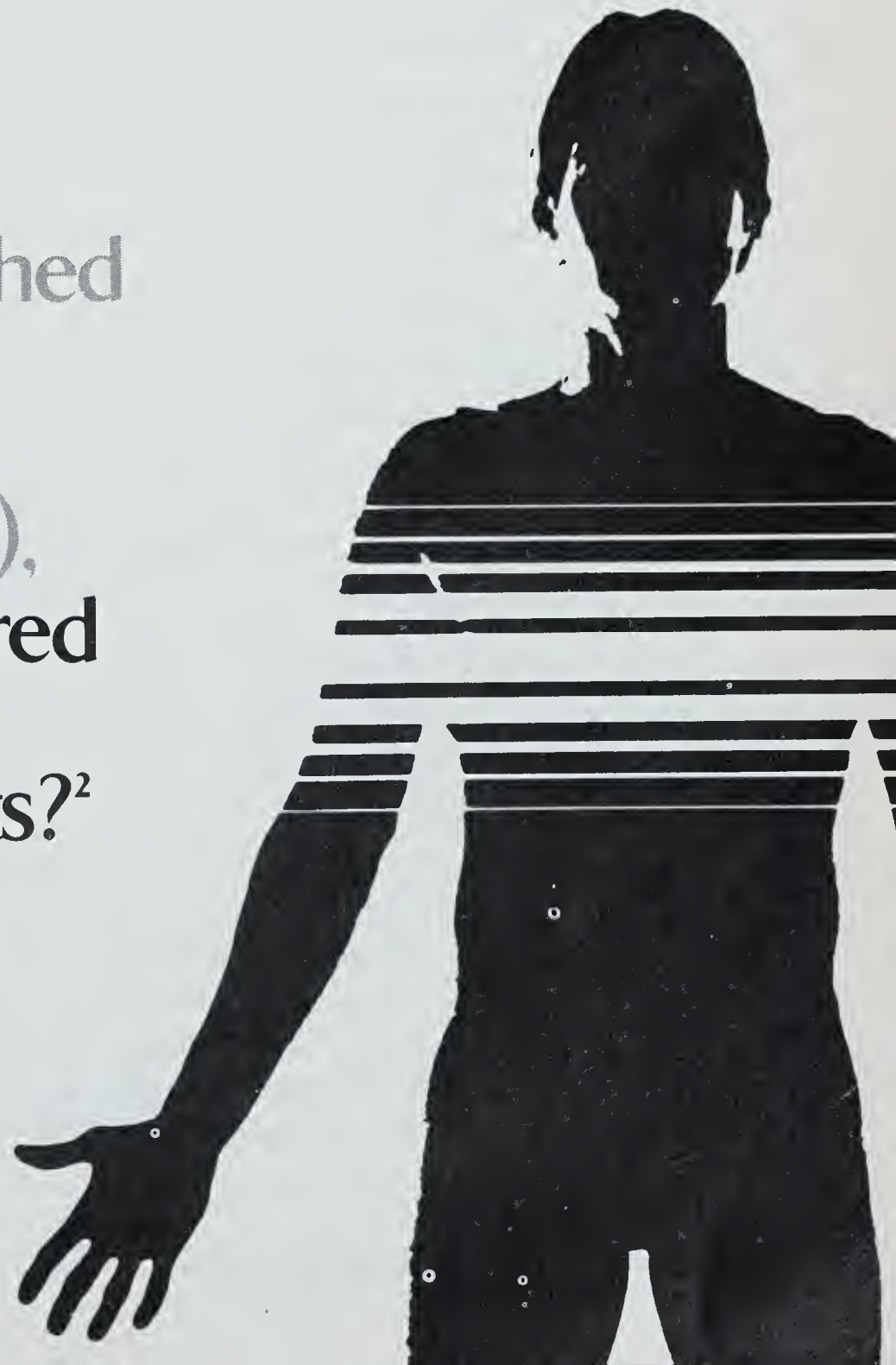
additional references on request

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?[2]



Defense Mechanisms, Infection, Antibiotic Therapy, and Immunizations in the Elderly

Leroy F. Harris, M.D.*

Infection is responsible for significant morbidity and mortality in the elderly patient.[1] Physicians taking care of these patients must understand defense mechanisms, the types of infection and their clinical manifestations, antibiotic therapy and immunizations for the elderly. This paper is a review of these topics.

The host defense mechanisms are complicated by certain diseases of aging. Obliterative arterial disease, especially in association with diabetes mellitus predisposes to peripheral leg ulcers which in turn become invaded by bacteria. Aspiration pneumonia and decubitus ulcers are a common sequel to cerebrovascular accident with its associated depressed level of consciousness. Benign prostatic hypertrophy and prostatic cancer causing urinary tract obstruction require instrumentation and frequently are associated with urinary tract infection and gram negative sepsis. Finally, neoplasms, immunosuppressive therapy, and diabetes mellitus are associated with depressed humoral and cell mediated immunity and abnormal polymorphonuclear leukocyte function.[1]

Specific defense mechanisms of the elderly in the absence of underlying diseases, such as diabetes mellitus, renal disease, peripheral vascular disease, and neoplasia reveal few abnormalities when compared to healthy young patients. Polymorphonuclear function reveals normal bactericidal and serum opsonic activity however, chemotaxis of white cells may be diminished in the elderly. The humoral component of the host defense mechanism shows normal levels of IgG and IgA with depressed levels of IgM. IgE may be elevated and complement levels are normal to elevated. Cell mediated immunity as measured by skin testing with various antigens reveals a less vigorous reaction but no evidence of energy. Mitogenic stimulation of lymphocytes is delayed and less vigorous than in younger patients. It is concluded that specific defense mechanisms in the elderly, in the absence of underlying disease, reveal few abnormalities. Furthermore, any predisposition to infection or inability to respond adequately to infection is due to underlying disease.[2]

Many infectious diseases have different clinical manifestations and require alterations in therapy in the elderly. The incidence of tuberculosis in the elderly is disproportionately high. In one study, over 60% of new cases occurred in patients over 45 years of age. This group constituted 30% of the population; therefore, tuberculosis is a significant disease in the elderly. In addition, the elderly patient who has been exposed to tuberculosis in earlier years has a latent infection and activation can occur with immunosuppression.

Elderly patients may have classic manifestations of tuberculosis, however, the disease more often presents as a vague decline in general health which may be attributed to aging or depression. Up to 25% of elderly patients with tuberculosis have no fever and 20% may be asymptomatic. A chest x-ray may show an atypical

The Huntsville Clinic, 401 Lowell Drive SE, Huntsville, AL 35801.

radiographic pattern and tuberculin skin testing is negative in up to 20% of newly diagnosed cases of pulmonary tuberculosis.

Extrapulmonary tuberculosis in the elderly has shown an increasing prevalence in the past 2 decades and clinical manifestations may be subtle. Diagnosis is dependent on obtaining tissue and/or fluid from the suspected site.

Therapy for tuberculosis in the elderly is universally effective except in an overwhelming illness, in the moribond patient, or in the host with significant complicating disease. Compromised organ function which frequently accompanies aging may contraindicate certain drugs. Active liver disease is a relative contraindication to the combination of INH and rifampin, streptomycin should be avoided in patients with diminished renal or 8th cranial nerve function and ethambutol should not be used in the patient with visual problems. Specific drug regimens for the elderly include initial therapy for three months with a combination of INH 300 mg/d, rifampin 600 mg/d and ethambutol 15 mg/kg/d followed by twelve months of INH 300 mg/d and ethambutol 15 mg/kg/d. Another regimen is the combination of INH 300 mg/d and rifampin 600 mg/d for a total of nine months. In patients with active liver disease or substantially impaired liver function treatment with INH and ethambutol is recommended for a total of 18 to 24 months with the addition of streptomycin 1 gm/d for 2 to 3 months if there is extensive, cavitary, or life threatening disease.[3]

Mycobacterium tuberculosis isolates should be sent for sentisitivy testing because of the current resistance rate of 4% to INH and streptomycin and less than 1% to rifampin and ethambutol. During treatment monthly sputum specimens are required for AFB smear and culture until there are two consecutive negative specimens. Chest x-rays are obtained monthly until the chest x-ray clears or stabilizes and in the patient on INH and/or rifampin, monthly liver function tests should be obtained. After completing chemotherapy the patient may be discharged from care and instructed to return only if symptoms recur because treatment failure is rare in the patient who successfully completes therapy.[5]

Preventive therapy with INH for a positive tuberculin skin test no longer is given routinely to patients over 35 years old because of the high incidence of INH hepatitis in the elderly. Prophylactic therapy with INH for one year is recommended in patients over 35 years old if skin test conversion has occurred in the last year; the patient is a household or close contact of a case of active tuberculosis; the patient has a gastrectomy, silicosis, or diabetes mellitus; the patient is immunosup-

In 1980, when the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure published their recommendations, which Step-2 regimen best met their criteria for effectiveness, safety, simplicity of titration, convenience, and economy?[3]

pressed; or the patient has evidence of prior tuberculosis on chest x-ray and never has received treatment.[6]

Infectious endocarditis like tuberculosis is another disease which is becoming increasingly common in the elderly patient. The average age of patients with endocarditis, as well as the percentage of cases in patients over 60 years of age, has increased. There is a 30-45% occurrence rate of endocarditis in the aged in recent years versus a 1-2% occurrence rate in the pre-antibiotic era.

The clinical presentation of endocarditis in the elderly is similar to but less pronounced than that in the younger patient. In addition, symptoms of endocarditis in the elderly often are attributed to other more common conditions in this age group. Fever and weight loss may suggest the possibility of another infection or a carcinoma while neurologic symptoms may be attributed to atherosclerotic cerebrovascular disease. Heart murmurs of endocarditis incorrectly may be diagnosed as flow murmurs, calcific aortic stenosis, or papillary muscle dysfunction.

Predisposing conditions to endocarditis in the elderly are different from those of the younger patient. Approximately 50% of elderly patients have no valvular lesion and a significant percentage have sclerotic aortic valve disease or mitral valve disease secondary to papillary muscle dysfunction. Bacteremia leading to infectious endocarditis commonly arises from surgery, decubitus ulcers, dental manipulation, urinary tract infection, or pneumonia in the elderly patient.

The organisms causing endocarditis in the elderly are more virulent and include Staphylococcus aureus, enterococcus in the male as well as viridans Streptococcus. The aortic valve is involved more commonly than the mitral valve. Diagnosis less often is made antemortem and the prognosis of endocarditis is dismal with mortality rates up to 75%. Antibiotic therapy and indications for surgical replacement of the infected valve are similar to those in the younger patient. Because sclerotic valves can become infected, antibiotic prophylaxis during manipulations which cause bacteremia is indicated.[1, 7, 8]

Bacteriuria is an extremely common event in the elderly patients. Rates of bacteriuria approach 40% in patients in long-term hospital facilities and the incidence increases with age. The reasons are not clear but there are contributing factors which are thought to be important. In the male obstructive uropathy, instrumentation secondary to prostatic disease and decreased bactericidal secretions from the prostate associated with aging are considered to be important. Both the elderly male and female have diminished ability to

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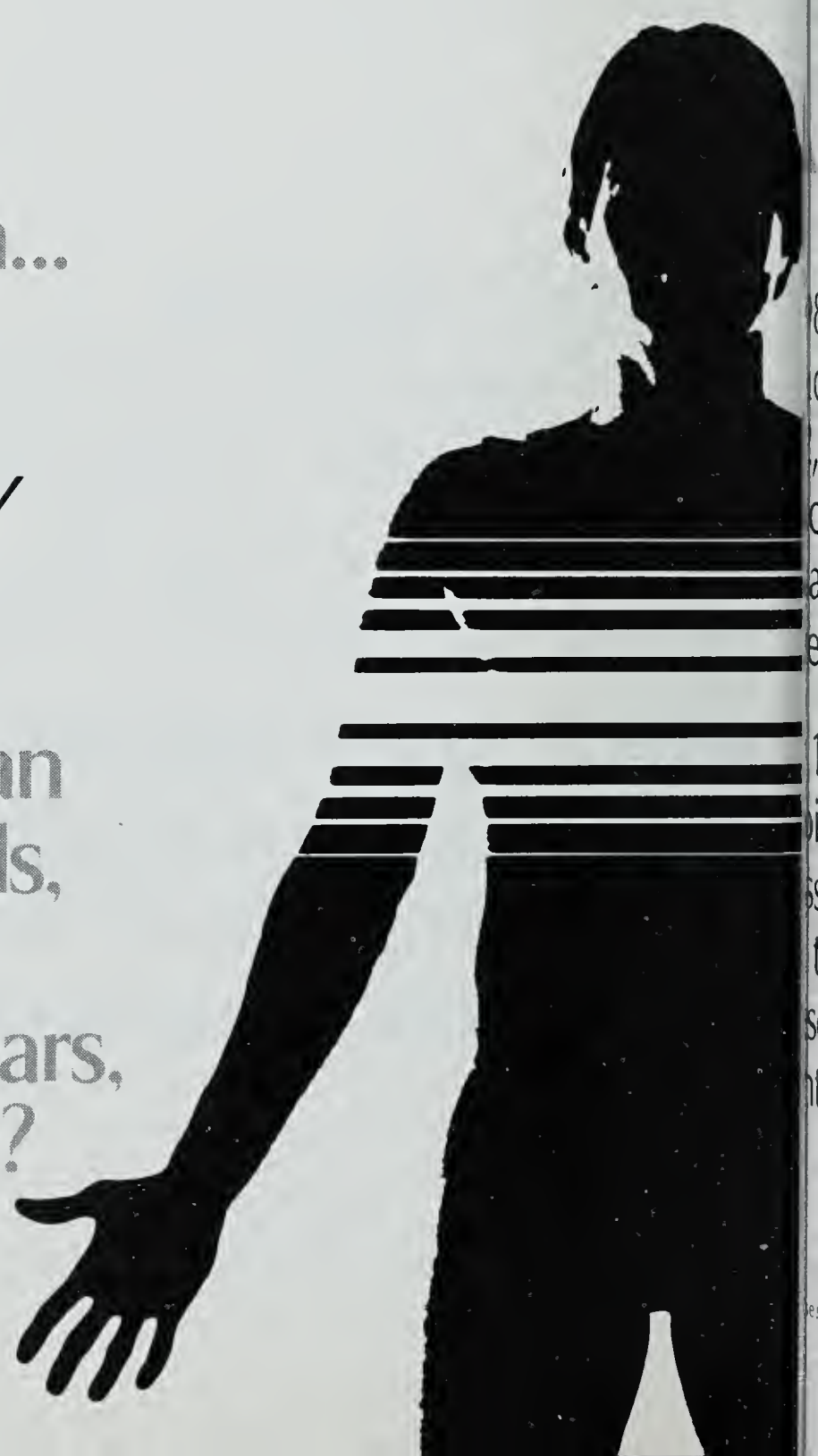

empty the bladder secondary to immobility and/or disease and the female has soiling of the perineum associated with fecal incontinence.

E. coli remains the most common etiologic organism causing bacteriuria in the elderly but other organisms such as Proteus, Klebsiella and Pseudonomas, are seen relatively more often than in the younger patient. Bacteriuria in the elderly frequently is not associated with deterioration of renal function in the absence of obstruction or anatomical abnormality of the urinary tract. Furthermore, it is often not associated with hypertension and does not appear to predispose to symptomatic urinary tract infections, pyelonephritis or gram negative sepsis.

Because bacteriuria in the elderly usually is a self limited infection, antibiotics used in treatment should be limited to an agent with few toxic side effects such as penicillin, a cephalosporin, or trimethoprim-sulfamethoxazole. These agents are excreted into the urine in high concentration, even in the presence of renal insufficiency. A relapse of the infection, defined as a reoccurrence with the same organism after appropriate therapy, usually occurs within the first two weeks but may be delayed in the patient with prostatitis. Such a relapse suggests that there is renal involvement, a structural abnormality of the urinary tract or chronic bacterial prostatitis. Management includes retreating for a prolonged period of time, such as three to six weeks, if there is no structural abnormality. If prostatitis is found then treatment with trimethoprim-sulfamethoxazole for 12 to 16 weeks is indicated. Reinfection, defined as a recurrence of bacteriuria with a new organism, may be infrequent or frequent. If infrequent, such as 1 to 2 times per year, each episode should be treated with a short course of antibiotics. If the reinfection rate is frequent but asymptomatic, treatment is best avoided because the disease is benign and not associated with deterioration or renal function. In addition, the toxic side effects of antibiotic treatment are increased and the frequent use of antibiotics may result in infection with resistant organisms. If reinfection is frequent and symptomatic, each episode should be treated with an appropriate antibiotic and then the patient should be placed on long-term suppressive therapy with trimethoprimsulfamethoxazole, ½ tablet, or nitrofurantoin, 100 mg every night for as long as the patient remains abacteriuric.

The length and route of treatment of bacteriuria in the elderly should be based on the location of the infection. Appropriate treatment for lower urinary tract infections includes therapy with kanamycin, 500 mg IM, or amoxicillin, 3 gm PO, as a single dose. Alternatively, a

nd there's more proof on the way!

82 will see the completion of the Multiple Risk ctor Intervention Trial (MRFIT)—a six-year, ,000-patient study assessing the factors that crease risk of cardiovascular disease. For the anagement of hypertension, the preferred ep-2 regimen in this study is reserpine-thiazide.

1978, in a preliminary report presented to the idemiology Section of the American Heart sociation (Dallas, Nov 1978), after 12 months the trial, fewer patients (5.3%) treated with serpine suffered depression than even the treated control group (7.7%)!

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SM-2348 11/81

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short course of an oral antibiotic such as amoxicillin, 500 mg. three times a day or cephalexin, 500 mg four times a day for 1 to 3 days may be given. Upper urinary tract infection should be treated with high dose parenteral therapy for 10-14 days.[9]

Bacteriuria associated with long-term Foley catheter is invariable despite the use of a closed system, antibiotic irrigation or long-term suppressive oral therapy. It frequently is limited to the bladder, asymptomatic and may not be associated with renal function deterioration. Treatment either will not clear the infection or will result in infection with a more resistant organism. Therefore, treatment should be restricted to the patient who is symptomatic, develops gram negative sepsis or shows renal function impairment and consists of parenteral therapy for 10 to 14 days with an appropriate antibiotic.

Infection remains a major cause of morbidity and mortality in the elderly patient and its effective treatment requires consideration of host factors unique to the elderly. Degenerative diseases of the elderly predispose to infection and also cause special treatment considerations. Peripheral vascular disease is associated with cellulitis and osteomyelitis and causes a decreased penetration of the antibiotic to the infected area. Ischemic bowel disease may predispose to abdominal sepsis and can be associated with decreased absorption of oral antibiotics. Congestive heart failure may be exacerbated by the high sodium loads of ticaricillin, carbenicillin and sodium penicillin and treatment of this disease with diuretics may potentiate the ototoxicity of aminoglycosides. Treatment with chloramphenicol or sulfonamides potentiate the hypoglycemic effect of sulfonylurea hypoglycemic agents used in the treatment of diabetes mellitus. The penicillins, cephalosporins, the tetracyclines, chloramphenicol and INH are associated with false positive urinary glucose reactions when tested with Clinitest® or Benedict's test. Diabetes also causes small vessel disease which impairs absorption of IM medications. The ability of penicillins and cephalosporins to cause neurotoxicity such as myoclonus, seizures and coma, is enhanced by the simultaneous occurrence of a cerebrovascular accident. Antibiotics have many interactions with coumarin type anticoagulants used in the treatment of pulmonary emboli, transient ischemic attacks, and myocardial infarction. Rifampin and griseofulvin diminish the effect of coumarin while broad spectrum oral antibiotics, sulfonamides and chloramphenicol potentiate the effect of coumarin.

Also important in the selection of antibiotic therapy in the elderly is consideration of the decline in phys-

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Salutensin® Salutensin-Demi™

(Hydroflumethiazide, Reserpine Antihypertensive Formulation)

Brief Summary of Prescribing Information (12) 10/27/78

For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy

Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ologic processes associated with aging. Diminished enal function as measured by diminished creatinine clearance occurs in elderly patients even in the face of a normal serum creatinine. Thus, toxic side effects result rom an increased serum level of those antibiotics which are cleared by the kidney. As a result neurotoxicty from high doses of penicillins and renal toxicity rom aminoglycosides may occur.

There are as yet undefined mechanisms which result n a higher incidence of adverse reactions to antibiotic herapy in the elderly. INH hepatotoxicity shows an ncrease with age, occurring with a 0.3% incidence in hose 20 to 34 years of age, and 2.3% incidence in atients above 50 years or age. Hypersensitivity reacions to antibiotics also are more common in the lderly.[10]

Immunizations are an important area of care for the lderly. The majority of cases of tetanus in the United States occur in persons over 50 years of age and a recent tudy shows that more than 50% of persons over 60 ears old have less than protective levels of tetanus and iphtheria antibodies.[11] For those patients never reeiving primary tetanus-diphtheria immunization, a ose of both toxoids should be given followed by nother dose in 4 to 8 weeks, followed by another dose n 6 to 12 months after the second dose. Booster imnunizations should be given every 10 years.[12]

Influenza vaccination is another immunization which is indicated for the elderly patient. This is recommended because there is excessive mortality associated with influenza in patients over 65 years of age as well as in chronically ill patients of all ages.[13] An English study demonstrated that elderly patients in a nursing home developed lower post-vaccination antibody levels than younger patients but that these levels were effective in decreasing the mortality rate and the incidence of pneumonia as compared to non-vaccinated patients. This benefit presumably was secondary to protection from influenza and its pulmonary complications.[14]

The final immunization recommended for the elderly is the pneumococcal vaccine. This vaccine is derived from the capsules of the fourteen most common types of pneumococci which cause disease. The pneumococcus is the major cause of community acquired pneumonia, causing approximately one half million cases per year in the United States. Although antibiotics have decreased the mortality of pneumococcal pneumonia, there remains a considerable fatality rate. The highest mortality rate from pneumococcal pneumonia occurs in elderly patients over 50 years old and in patients with chronic lung disease. Therefore, the pneumococcal vaccine, like the influenza vaccine, is indicated for

continued on page 50

ADVERSE REACTIONS

Hydroflumethiazide

Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine

Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

1 tablet b.i.d.

SUPPLIED

Bottles of 100 and 1000 scored 50 mg. tablets.

References:

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3. The 1980 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 140:1280-1285, 1980.

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Sudden Infant Death Syndrome

A program for assessment and home monitoring

Kay Hendrix, R.R.T. and Margaret Watkins, M.D.*

Sudden Infant Death Syndrome (SIDS) is the unexpected and unexplained death of an apparently healthy infant occurring during sleep. The peak age range is three to four months, with a higher incidence among males and the winter months. SIDS is the leading cause of infant deaths in the United States, according for almost 10,000 deaths annually.[1] In Alabama in 1980 there were 108 such deaths.

The etiology of SIDS is as yet undetermined, although causation is likely multifactorial. Considerable research has currently identified three groups of infants at risk for SIDS: the siblings of an infant dying of SIDS,[2, 3] infants experiencing a ''near-miss'' episode,[4] and infants with prolonged apnea and/or bradycardia in the neonatal period,[5, 6]

Identification of infants at risk, intervention through monitoring and evaluating, and prevention of SIDS by home monitoring programs have been the avid interests of Drs. Kelly and Shannon and their colleagues at Massachusetts General Hospital (MGH) for the past decade.[2, 7] They have developed an extensive evaluation, have published numerous articles about SIDS, and have been of invaluable assistance to us and others developing similar programs locally and regionally.

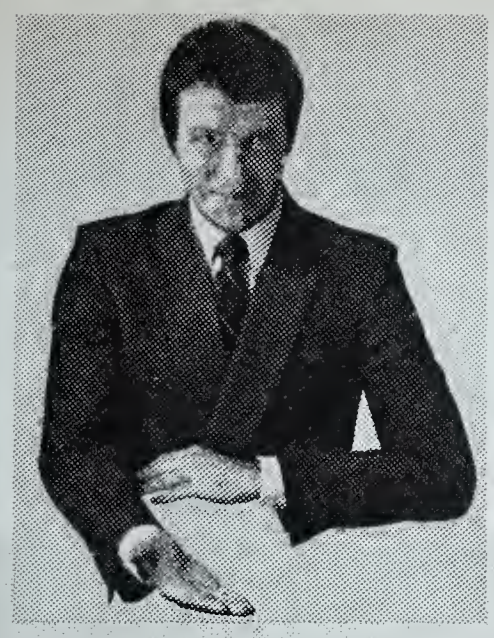
Brookwood Medical Center (BMC) initiated a program of screening and home monitoring for patients at risk for SIDS in March, 1981. This program was developed following the guidelines of the MGH program and with continued support of Dr. Kelly's group. The purpose of this report is to describe our program and share our results to date with physicians and other medical personnel within the state.

An infant who is determined at risk for SIDS by the primary care physician according to the above three risk factors may be referred to BMC for evaluation. The infant is admitted to the parenting room of the nursery for an overnight stay. This room is designed to be as much like home as possible, with beds to accommodate the parents who continue to do all routine care of their baby. History and physical assessment are made by a staff pediatrician and nursery nurse.

At the infant's usual bedtime, he is attached to a Healthdyne Infant Monitor equipped with a cassette recorder to record respiratory patterns and cardiac activity. See Figure. This twelve hour pneumogram is supervised by the neonatal respiratory therapists, and a log is kept of any alarm (apnea or bradycardia) activations and state of patient during such alarms.

Upon completion of the pneumogram, the program coordinator reviews the log, completes a history form and sends the tape to MGH's Pediatric Pulmonary Laboratory for interpretation. Results are telephoned to the coordinator within 72 hours, and she in turn notified the admitting and referring physician(s). A decision is made as to further treatment, further diagnostic evaluation and the need for follow-up pneumograms. If the physician decides that the patient should be placed on

* Brookwood Medical Center, Birmingham, Alabama.
Reprint address: Kay Hendrix, R.R.T., Newborn Intensive Care Unit, 2010 Brookwood Medical Center Drive, Birmingham, Alabama 35209.



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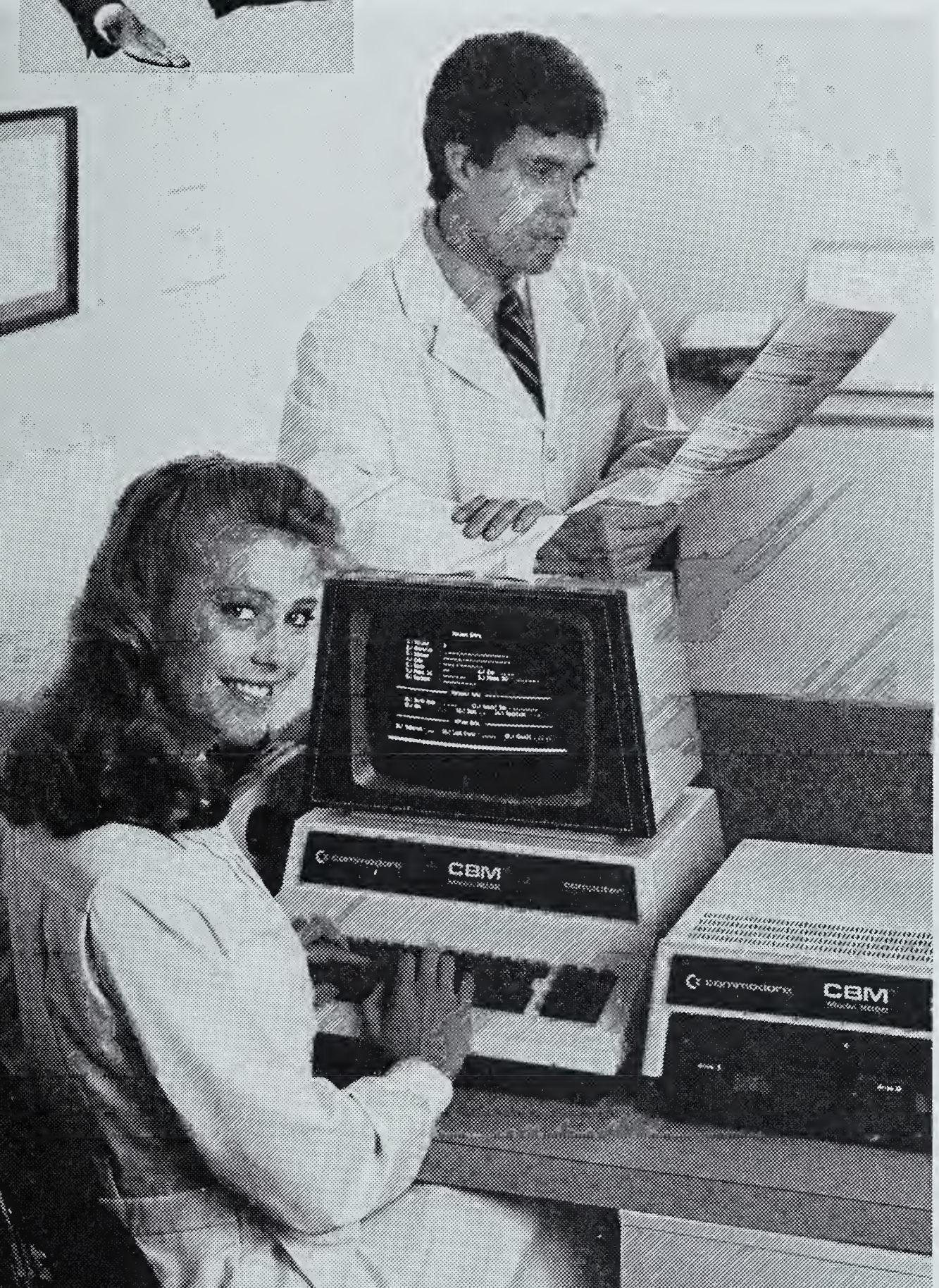

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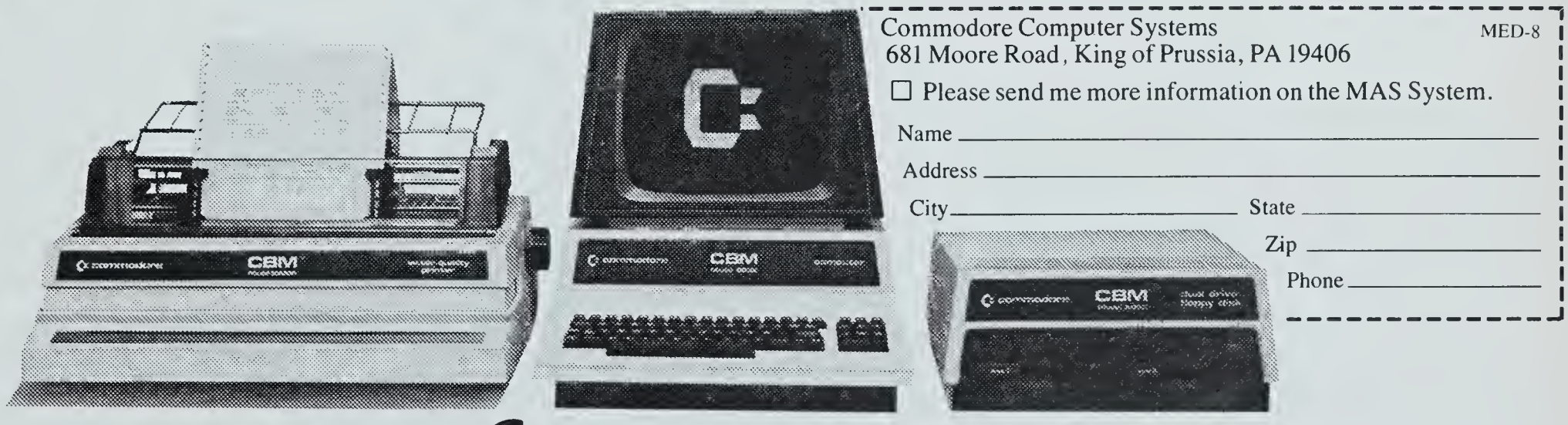

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an apnea monitor at home, the infant is entered into BMC's Home Monitoring program.

A home equipment dealer brings a Healthdyne Monitor to the hospital (or to the patient's home in some cases) and instructs the parents in the technical aspects of the equipment. The therapist shows the parents how to place the electrodes and belt on the infant and adjusts the monitor's sensitivity controls. Instructions in infant cardiopulmonary resuscitation (CPR) is given with the parents practicing on an infant mannequin. The parents are taught how to respond to an alarm by observation and stimulation, and other techniques of home monitoring. They are given booklets on home monitoring, CPR instructions, log and journal forms to record alarms and intervention activities at home. The equipment dealer and respiratory staff are available at all times to assist with technical or other problems encountered in monitoring.

For patients with abnormal pneumograms, whether on home monitoring or not, follow-up pneumograms are recommended every 6-8 weeks until two consecutive normal tracings have been obtained. At this time a weaning schedule is established for infants on monitors such that this support is slowly discontinued as the parents feel comfortable. Log and journal forms are reviewed with the parents at each admission, and weekly contact is maintained with each family. Most infants meet the criteria of two normal pneumograms and no bona fide alarms for eight weeks by the time they are

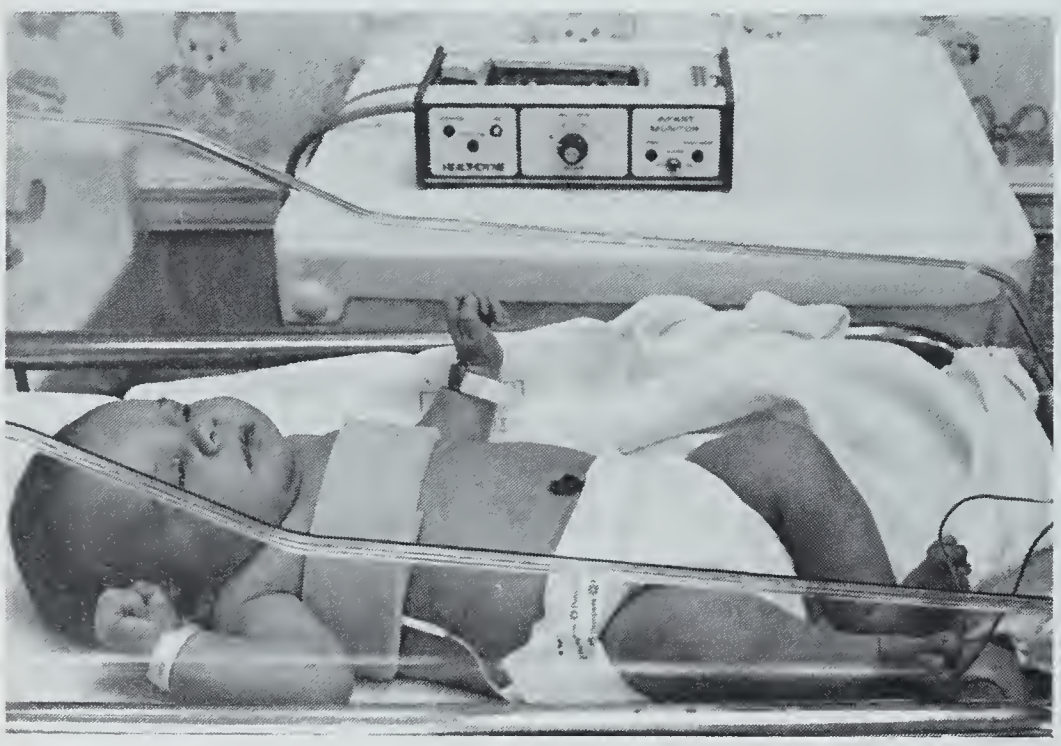

Figure 1

6-8 months old and consequently beyond the age of highest risk for SIDS.

Results

Since March, 1981, we have done a total of 45 pneumograms on 28 patients and have 19 infants enrolled in the home monitoring program. Six infants have had documented apneic episodes requiring stimulation. None have thus far required CPR. Some of the alarm episodes have been false-positive alarms related to technical problems such as loose leads, electrode malpositioning or poor sensitivity adjustment. On a number of occasions when the parents have responded to the alarm the infant is breathing normally. We presume that in these cases the infant's apneic episode has exceeded the delay interval set on the monitor but he has resumed spontaneous respirations in response to the sound of the alarm or to his own self-regulating mechanisms.

A number of patients have required evaluation and/or therapy in addition to what is initially performed by the referring physician. These have included barium swallow and institution of anti-reflux measures, electroencephalogram to rule out seizures as a cause of apnea, and blood transfusions for correction of severe anemia. Five patients have been treated with theophylline preparations at home because of abnormal pneumograms with excessive periodic breathing or multiple short apneic episodes. Serum theophylline levels are monitored and pneumograms repeated both on therapy and after it is discontinued.

Many adjustments are necessary for parents who undertake home monitoring. Use of the monitor necessitates many adaptations and alterations in the family lifestyle.[8] We try to make parents aware of these modifications beforehand and offer psychological and emotional support to them during the monitoring period. The parents have expressed gratitude for the relief and reassurance the monitor has afforded them. They have felt that the benefits far outweigh the inconvenience that such a situation may have caused them.

Establishment of a screening and monitoring program for SIDS requires a major commitment of time and personnel and a willingness for emotional involvement with families that should not be undertaken casually. We feel that this program provides a much-needed service to the community and anticipate an ever-increasing demand for such services. Both the program coorinator and the physician program director are willing to assist other hospitals in establishing a similar program to meet the needs of infants in this state.

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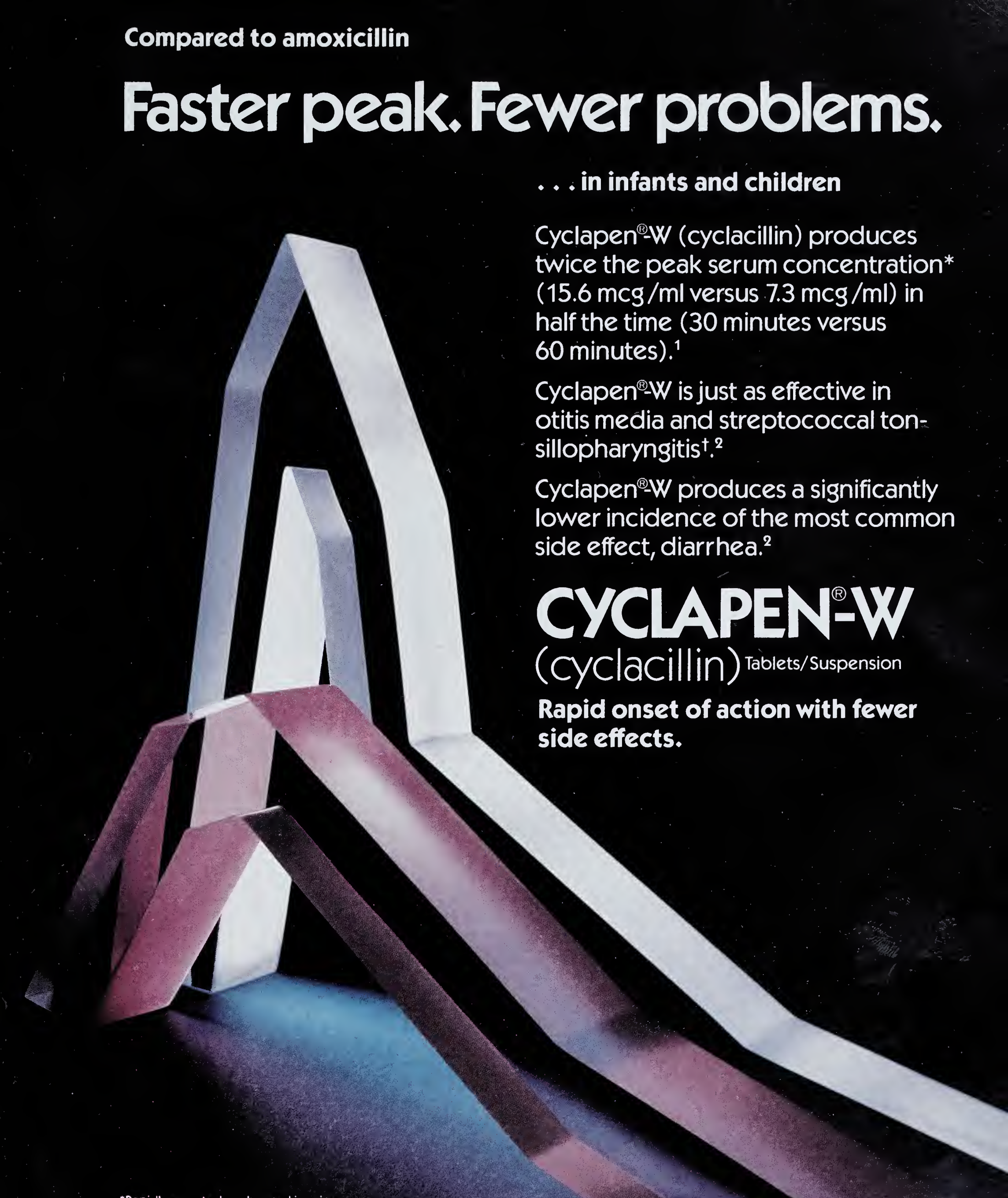

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1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.
2. Multicenter trials. Data to be published.

See important information on page after next.

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Indications
Cyclocillin hos less in vitro activity than other drugs in the ompicillin closs ond its use should be confined to these indications: Treotment of the following infections:

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Tonsillitis ond phoryngitis coused by Group A beto-hemolytic streptococci

Bronchitis ond pneumonio coused by *S. pneumoniae* (formerly *D. pneumonioe*)

Otitis medio coused by *S. pneumonioe* (formerly *D. pneumonioe*) ond *H. influenzoe*

Acute exocerbotion of chronic bronchitis coused by *H. influenzoe**

*Though clinicol improvement hos been shown, bocteriologic cures connot be expected in oll potients with chronic respirotory diseose due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentory) infections coused by Group A beto-hemolytic streptococci ond stophylococci, nonpenicillinose producers.

URINARY TRACT INFECTIONS coused by *E. coli* ond *P. mirobilis*. (This drug should not be used in ony *E. coli* ond *P. mirobilis* infections other thon urinory troct.)

NOTE: Perform cultures ond susceptibility tests initiolly ond during treotment to monitor effectiveness of theropy ond susceptibility of bocterio. Theropy moy be instituted prior to results of sensitivity testing.

Contraindications Controindicoted in individuols with history of on ollergic reoction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less in *vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of ontibiotics moy promote overgrowth of nonsusceptible orgonisms. If superinfection occurs, toke oppropriote meosures.

PREGNANCY: Pregnoncy Cotegory B. Reproduction studies performed in mice ond rots ot doses up to 10 times the humon dose reveoled no evidence of impoired fertility or horm to the fetus due to cyclocillin. There ore, however, no odequote ond well-controlled studies in pregnont women. Becouse onimol reproduction studies ore not olwoys predictive of humon response, use this drug during pregnoncy only if cleorly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in humon milk. Becouse mony drugs ore, exercise coution when cyclocillin is given to o nursing womon.

Adverse Reactions Orol cyclocillin is generolly well toleroted. As with other penicillins, untoword sensitivity reoctions ore likely, porticulorly in those who previously demonstroted penicillin hypersensitivity or with history of ollergy, osthmo, hoy fever, or urticorio. Adverse reoctions reported with cyclocillin: diorrheo (in opproximotely 1 out of 20 potients treoted), nouseo ond vomiting (in opproximotely 1 in 50), ond skin rosh (in opproximotely 1 in 60). Isoloted instonces of heodoche, dizziness, obdominol poin, voginitis, ond urticorio hove been reported. (See WARNINGS) Other less frequent odverse reoctions which moy occur ond ore reported with other penicillins ore onemio, thrombocytopenio, thrombocytopenic purpuro, leukopenio, neutropenio ond eosinophilio. These reoctions ore usuolly reversible on discontinuotion of theropy.

As with other semisynthetic penicillins, SGOT elevotions hove been reported.

As with ontibiotic theropy generolly, continue treotment ot leost 48 to 72 hours ofter potient becomes osymptomotic or until bocteriol erodicotion is evidenced. In Group A beto-hemolytic streptococcol infections, ot leost 10 doys' treotment is recommended to guord ogoinst risk of rheumotic fever or glomerulonephritis. In chronic urinory troct infection, frequent bocteriologic ond clinicol opproisol is necessory during theropy ond possibly for severol months ofter. Persistent infection moy require treotment for severol weeks.

Cyclocillin is not indicoted in children under 2 months of oge.

Potients with Renol Foilure Cyclocillin moy be sofely odministered to potients with reduced renol function. Due to prolonged serum holf-life, potients with vorious degrees of renol impoirment moy require chonge in dosoge level (see DOSAGE AND ADMINISTRATION in pockoge insert).

Dosage (Give in equolly spoced doses)

INFECTION	ADULTS	CHILDREN*
Respirotory Troct		
Tonsillitis & Phoryngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis ond Pneumonio		
Mild or Moderote Infections	250 mg q.i.d.	50 mg/kg/doy q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/doy q.i.d.
Otitis Medio	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy†
Urinory Troct	500 mg q.i.d.	100 mg/kg/doy

*Dosoge should not result in o dose higher thon thot for odults.
†depending on severity

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The Community Surgeons' Role in the Training of Family Practice Residents

William R. Shamblin, M.D.*
R. Joe Burleson, M.D.†
C. Neil Moss‡

Approximately thirteen years ago Dr. Tinsley R. Harrison, who was then Chairman of the Department of Internal Medicine, University of Alabama School of Medicine, Birmingham, came to Tuscaloosa to speak to the County Medical Society concerning the availability, or lack thereof, of physicians in the State of Alabama. He noted that if the physician specialization and urbanization that had occurred during the previous few decades were allowed to continue fewer and fewer physicians would be available to practice in the smaller communities in the State of Alabama.

With this in mind, Dr. Harrison, as well as other physicians throughout the state, felt that a return of a true Family Physician was necessary. Programs subsequently were soon established by the State of Alabama, in Huntsville and Tuscaloosa for the training of Family Practice Physicians. Similar programs were later established in several other locations throughout the state.

In 1972, Dr. William R. Willard was brought to Tuscaloosa to establish a Family Practice Residency Program at The University of Alabama. It was named The College of Community Health Sciences. Shortly after the establishment of the residency, the College was expanded to include clinical teaching of medical students in their third and fourth years. The College in Tuscaloosa continues as a part of the three campus medical system of The University of Alabama School of Medicine, including Birmingham, Huntsville and Tuscaloosa.

As the College developed, private physicians and surgeons gradually became more and more involved in the teaching program. Presently there are approximately forty surgeons and surgical subspecialists in practice in Tuscaloosa and almost all of them are actively involved in the teaching program in a very positive way. All of our surgeons are board certified or qualified.

These practicing surgeons have followed the guidelines for the surgical training of family practice residents given by The American Medical Association as essentials for an accredited residency. These guidelines[1] stated:

> The resident should acquire competency in the recognition and management of surgical emergencies and when referral of them for specialized care is appropriate. He should be able to recognize conditions that preferably may be managed on an elective basis.
>
> It is important for him to appreciate the kinds of surgical treatment that might be employed for his patients as well as the problems that might arise from them. Knowledge of these matters enables him to give proper advice, explanation, and emotional support to his patients.

* Associate Professor and Chief, Division of Surgery, College of Community Health Sciences, University of Alabama, University, Alabama.
† Associate Professor and Director of Surgical Education, College of Community Health Sciences, University of Alabama, University, Alabama.
‡ Sophomore Medical Student, University of Alabama School of Medicine, Birmingham, Alabama.

> He should be trained in basic surgical principles, and acquire the technical proficiency required for those surgical procedures a Family Physician may be called upon to perform. If he expects to include surgery as a major aspect of his regular practice, he must obtain additional training.

With these directions in mind the local program attempts to teach the family practice residents technical, diagnostic and therapeutic skills that they can use in their practice.

Twelve residents enter the Family Practice Residency Program in Tuscaloosa each year. Presently, our faculty consists of one cardiovascular surgeon, nine general surgeons, several thoracic surgeons, ophthalmologists, otolaryngologists, neurosurgeons, anesthesiologists, urologists, emergency physicians, orthopedists and a proctologist.

The family practice resident takes eight weeks of general surgery. Other requirements also include eight weeks on emergency medicine, four weeks on orthopedic surgery, and two weeks each of ophthalmology and otolaryngology.

In addition to these requirements, electives are provided in neurosurgery, urology, cardiovascular surgery, thoracic surgery, anesthesiology, and proctology.

Residents are required to attend all surgical or surgical subspecialty conferences on a regular basis and are periodically required to formally organize and present conferences.

Having no surgical speciality residents, the family practice residents are given more responsibility regarding the management of surgical patients. The initial history and physical examination on hospitalized patients are performed by the resident and his findings are discussed with the surgical consultant. Also, appropriate pre-operative evaluations and preparations are ordered by the resident under the direction of the surgeon. At the time of surgery the residents almost always first assist with the operative procedure and only occasionally function in the second-assistant capacity on a complex case. Following the procedure the post-operative orders are written by the resident. The progress notes as well as the discharge summary are usually provided by the resident. All of the resident's post-operative management is under the supervision of the attending surgeon. It is usually necessary for the attending to provide closer observation and supervision than one would for a surgical resident, however, the family practice residents of this program have accepted all responsibilities as a challenge and have performed admirably. Their role is similar to that of a junior surgical resident with the exception of the ''performance'' of operative procedures.

Because of the short time of exposure to surgery, it is acknowledged that the family practice resident is not able to become completely proficient in the performance of many technical skills, however, instruction in most skills is provided during his rotation. He/she is instructed in proctoscopy, closed tube thoracotomy, endotrachial intubations, tracheostomy, placement of a central venous line, intravenous cutdowns, paracentesis, peritoneal lavage, electrosurgery, minor surgical procedures, and suturing. In addition, the resident is instructed in closed reductions of simple fractures, and office procedures used in all the surgical areas.

In a survey of our former residents who are now engaged in active practice, our graduates were questioned regarding the adequacy of their instruction by the community surgeons in technical, diagnostic, and therapeutic skills; and whether or not these skills were widely used in practice. These residents felt that during their training period they had received a good foundation in pre-operative and post-operative evaluation, surgical preparation, and post-operative care of surgical patients. They were complimentary regarding their training in the management of acute surgical problems such as the acute abdomen and trauma. The one most valued experienced was the ''one-to-one'' relationship that they experienced in the preceptor-type working environment.

It was felt, however, by some that additional electives in the certain areas would have been helpful. These included additional orthopedic surgery (with particular emphasis on fracture management and casting), sigmoidoscopy, diagnostic procedures used in otolaryngology, and minor surgical procedures.

It seems evident that the family practice resident's surgical training can be provided by qualified part-time and voluntary surgical faculty. Our goal remains to help him become confident in handling emergencies pending the availability of the surgical consultant; and to expose him to a surgical experience that will give him the technical, diagnostic, and therapeutic skills that he will use in his own field of practice.

The dream of Dr. Harrison and other leaders for the development of this new specialty has come true. The fulfillment of this dream has had several beneficial results. Family practice residents are being well trained in qualified community institutions. Such programs are also beneficial to the attending surgeons. Without question, the stimulus provided by the presence of residents and students and the continuing education therefore required greatly enhances the surgeons' ability to provide an ever improving quality of medical care for the community.

Reference

1. 1980/1981 Directory of Residency Training Programs. American Medical Association, Chicago, Ill., page 19, 1980.

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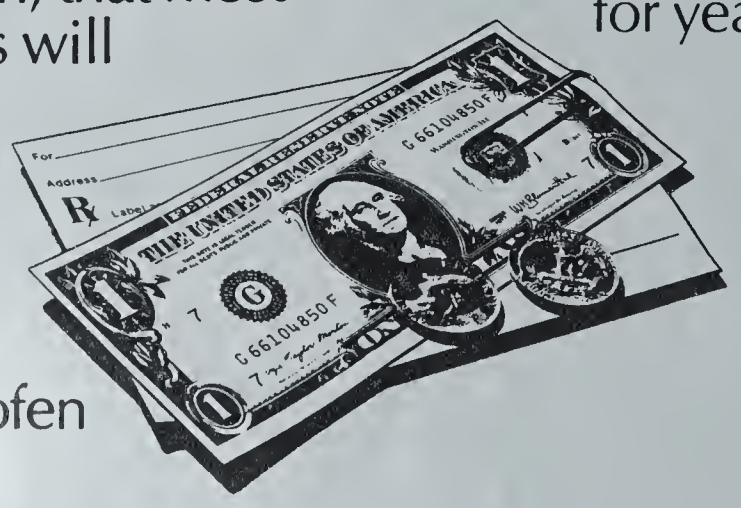

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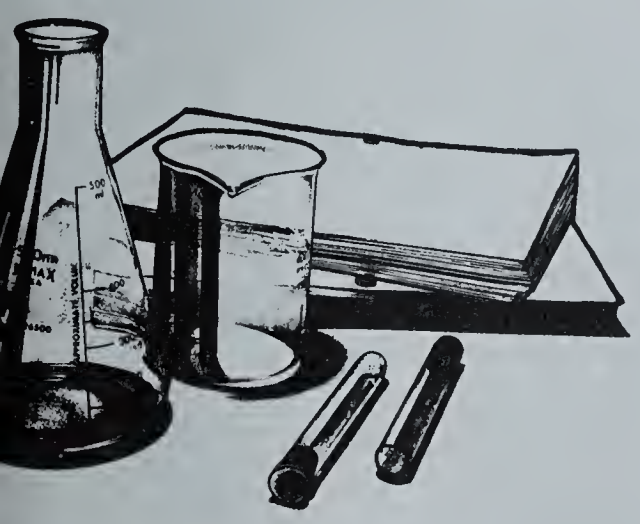

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RF-009

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INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally; however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: *Coumarin-type anticoagulants.* The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

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Trigeminal Neuralgia Treatment by Percutaneous Radio-Frequency Rhizotomy*

J. Garber Galbraith, M.D.† and H. Evan Zeiger, M.D.‡

Introduction

Trigeminal neuralgia (tic douloureux) is a painful disorder of unknown etiology characterized by short paroxysms of excruciating facial pain. The pain is limited to the distribution of one or more divisions of the trigeminal nerve, most often involving the lower jaw, and less frequently, the cheek and forehead. Paroxysms of pain can often be precipitated by touching a trigger zone in the involved area. Between attacks the patient is free of pain and the neurological examination is entirely normal. Diagnosis is based on the characteristic type of paroxysmal pain, precipitated by tactile stimuli, along with the absence of any objective neurological deficit. Symptomatic trigeminal pain due to dental pathology, intracranial tumor, or aneurysms must be differentiated by careful examination and appropriate studies.

This disorder affects predominately the elderly; it occurs rarely under the age of 40. No etiological factor or demonstrable pathology has been proven. The natural history of this disorder is a gradual progression of frequency and severity of the bouts of pain as the patient gets older. Spontaneous remissions are frequent and render the efficacy of any treatment difficult to evaluate. However, the pain inevitably recurs weeks or months later with increasing severity so long as the individual survives, or until definite surgical treatment is instituted.

* From the Division of Neurosurgery, Department of Surgery, University of Alabama School of Medicine, Birmingham, Alabama.
† Professor of Surgery, University of Alabama School of Medicine.
‡ Assistant Professor of Neurosurgery, University of Alabama School of Medicine.

Clinical Management

Ever since the classical description of trigeminal neuralgia by Fothergill in 1773, various medications have been tried with generally disappointing results. Today, two anticonvulsant drugs, carbamazepine and phenytoin socium constitute the most effective medical therapy. Therapeutic levels of the drugs must be verified by blood levels and should be continued as long as there is effective pain relief. In most cases, drug therapy ultimately fails or is discontinued because of undesirable side effects, so that most patients with severe pain ultimately require surgical measures for relief.

Intracranial operations for relief of pain include the classical temporal craniotomy for sensory root section or decompression and neurolysis of the ganglion and sensory root (Tarnhoj),[1] and more recently, the neurovascular decompression of the sensory root of the trigeminal nerve in the posterior fossa.[2] Sensory root section affords permanent relief of pain but renders the affected area of the face numb. The decompression procedures afford pain relief in a high percentage of cases with good preservation of sensation in the face. However, there is a significant recurrence rate with these decompression procedures, necessitating repetitive operative intervention.[3] As an alternative to a ma-

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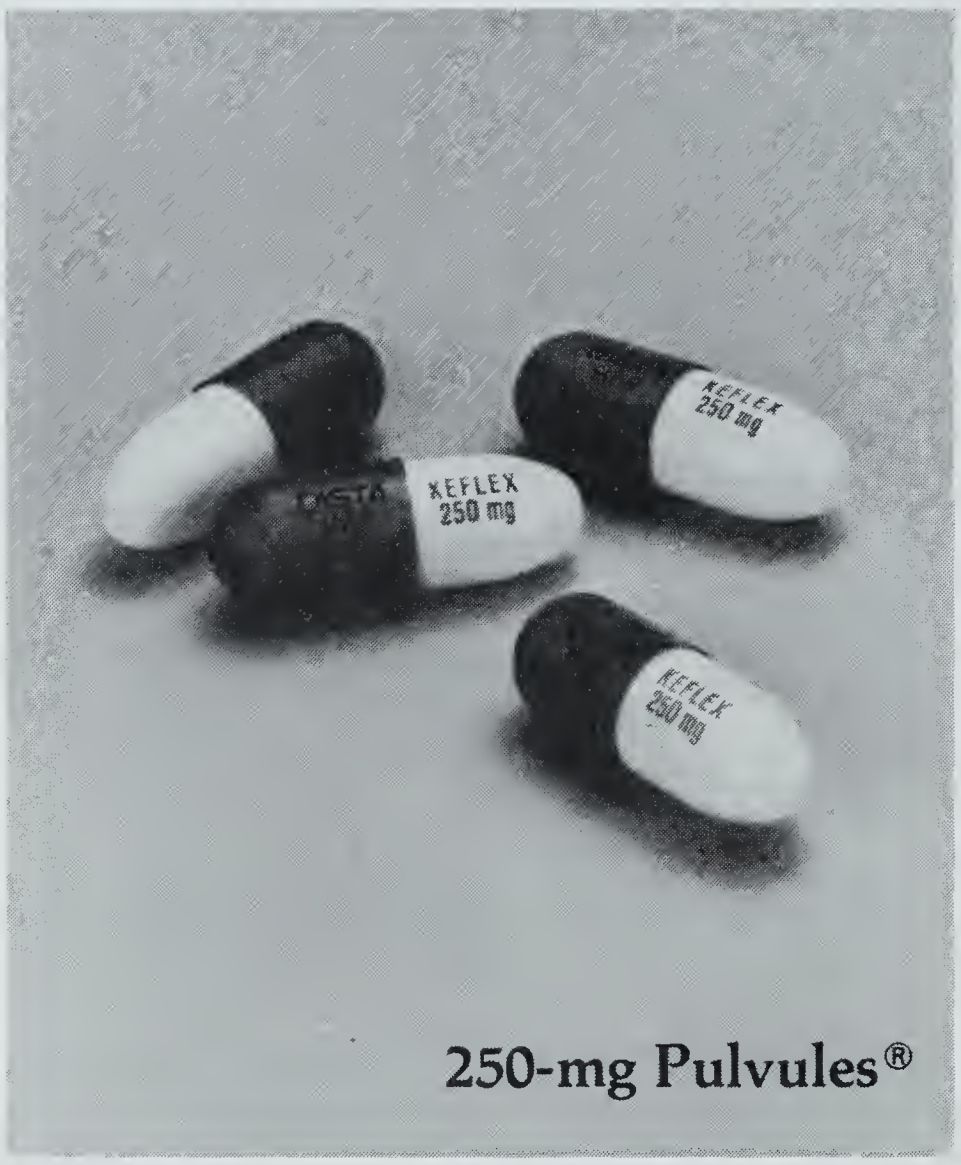

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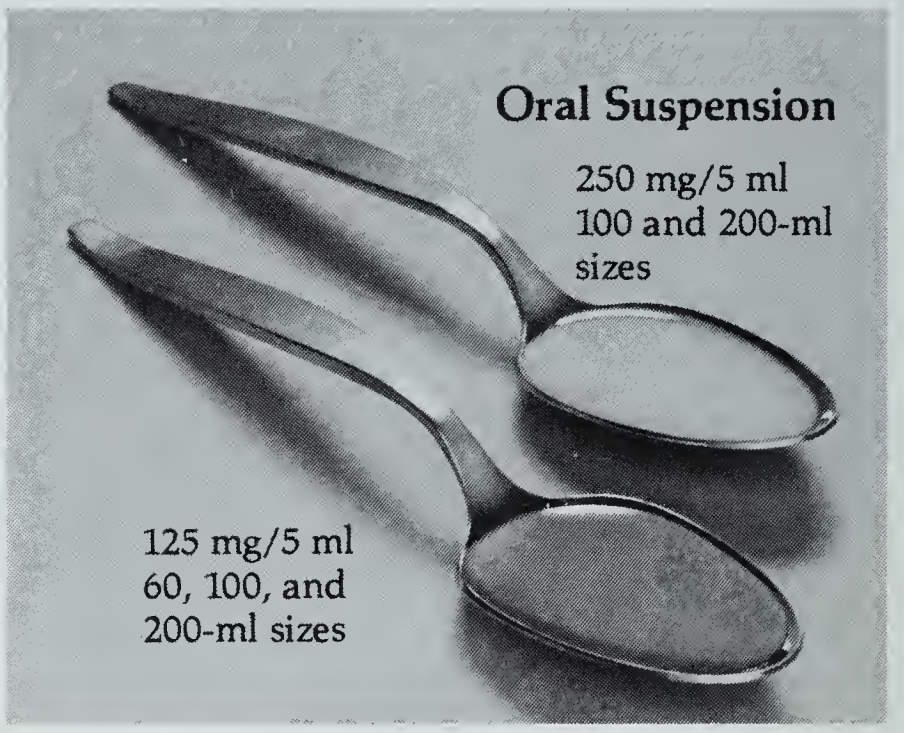

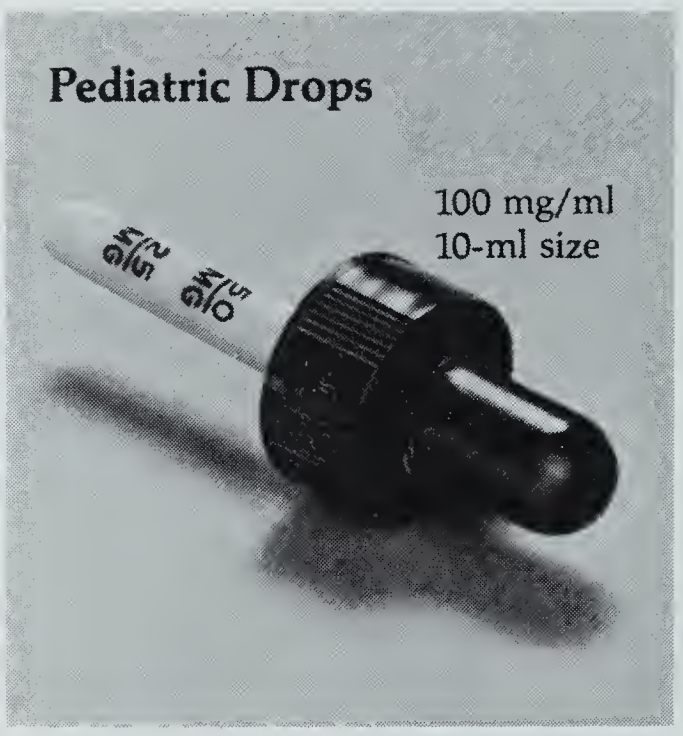

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jor intracranial procedure in these elderly patients, various injection procedures have been advocated. Alcohol injection of the branches of the trigeminal nerve affords only temporary relief. Injection of the Gasserian ganglion itself with a variety of agents has been reported, but has generally been abandoned because of poor results, undesirable side effects, and technical difficulties.

Percutaneous Rhizotomy

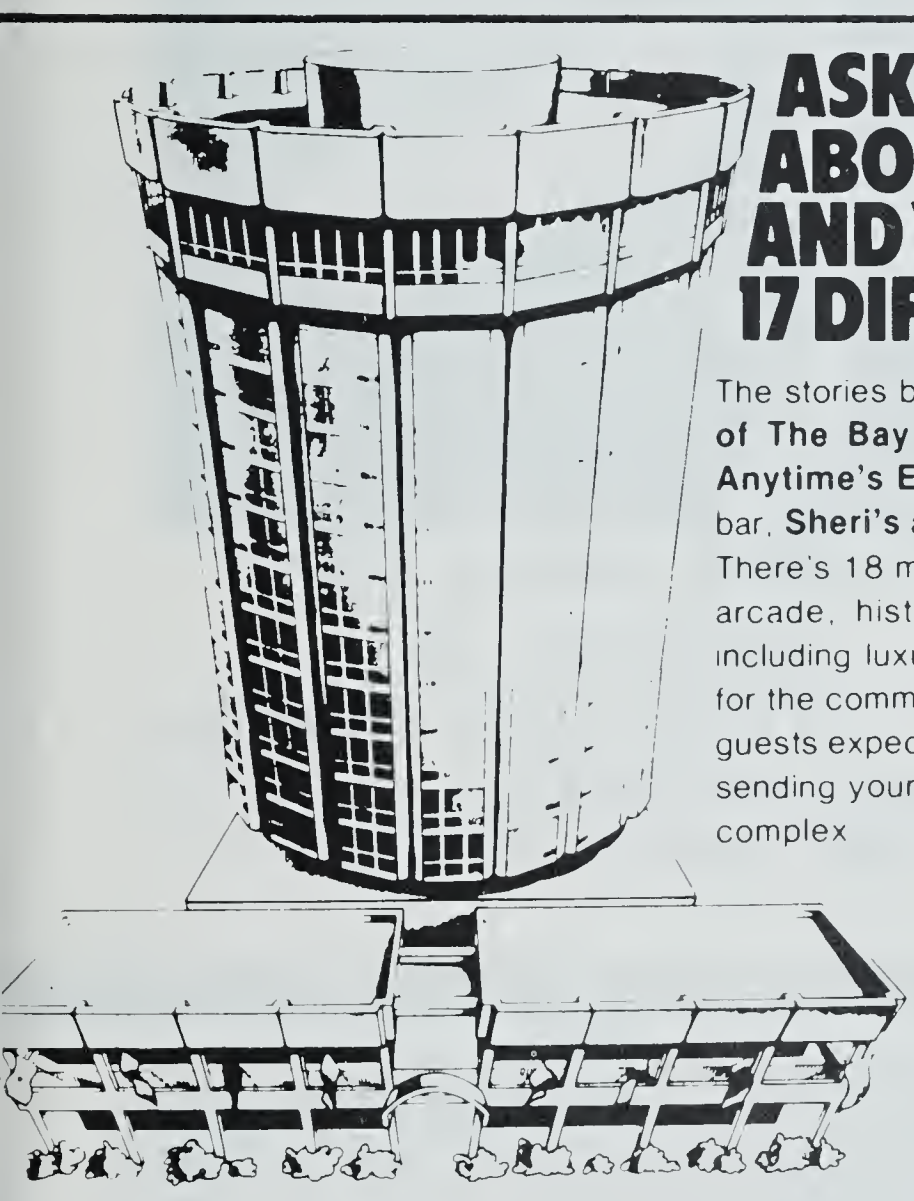
Kirschner in 1931 reported electrocoagulation of the Gasserian ganglion with success but the procedure was abandoned because of frequent injury to adjacent nerves and arteries. However, Sweet and Wepsic in 1970 reported their experience using a percutaneous approach to the Gasserian ganglion and sensory root by stereotactic guidance and using a radio-frequency current to produce a uniform lesion in the fibers of the sensory root of the trigeminal nerve.[4] Subsequently, several authors have reported large series of cases treated by this method with generally satisfactory results.[5, 6] The advantages of this method are:

1. Stereotactic guidance allows accurate placement of the electrode permitting precise lesion production involving only the fibers to the involved area.
2. Short-acting intravenous anesthetic allows painless, accurate placement of the electrode and permits the patient to be awake to cooperate with sensory testing to ascertain when a satisfactory lesion has been achieved.
3. The selective destruction of smaller poorly myelinated pain fibers by the current while the larger tactile fibers may be preserved, allows preservation of touch sensation in the face.

Further advantages of the procedure include a short duration of hospital stay, usually two or three days, and avoidance of a major intracranial operation in an elderly and often infirm individual.

Method

The procedure is carried out in the operating room with the patient in the recumbent position and with the C-arm fluoroscope in place. A #18 gauge thin walled spinal needle is introduced under local 1% lidocaine anesthesia through the cheek upward, medially, and posteriorly toward a point where the clivus and petrous ridge cross as visualized in the fluoroscope (Fig. 1). As the base of the skull is approached, intravenous brevital is administered for general anesthesia of brief duration. The needle is then introduced under fluoroscopic con-



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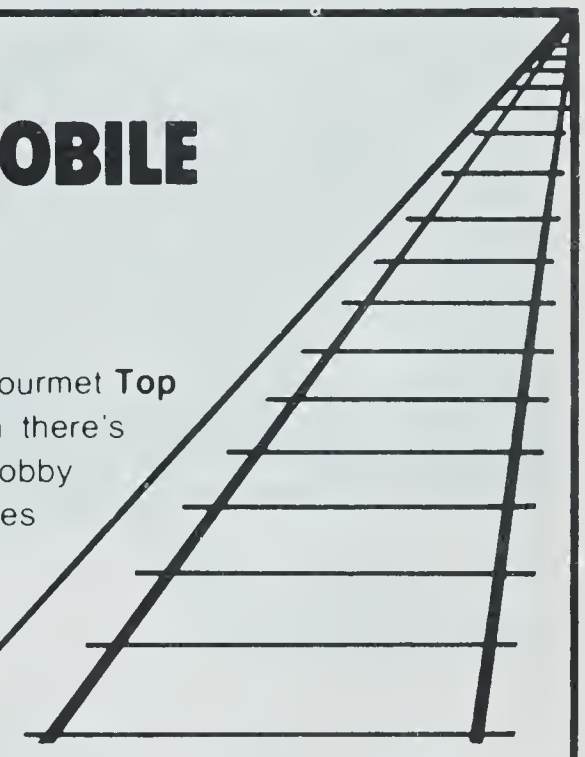

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As seen on admission

After one week of penicillin V-K therapy

Two weeks after initiation of TEGOPEN therapy

Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

*Data on file, Bristol Laboratories.

Brief Summary of Prescribing Information

TEGOPEN®
(cloxacillin sodium)
Capsules and Oral Solution

For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth	(14 patients)	9	5
All 14 healed, regardless of which antibiotic was administered.			
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus,* 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes,* and 1% beta-hemolytic *Streptococcus*.‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

TEGOPEN®
(cloxacillin sodium)
–effective therapy for staph infections of the skin and skin structures

WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

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trol through the foramen ovale and through the Gasserian ganglion into the sensory root of the trigeminal nerve (Fig. 2). Removal of the stylet allows escape of a few drops of cerebrospinal fluid. The electrode is then inserted through the needle into the sensory root. The patient is allowed to wake up and a small sensory

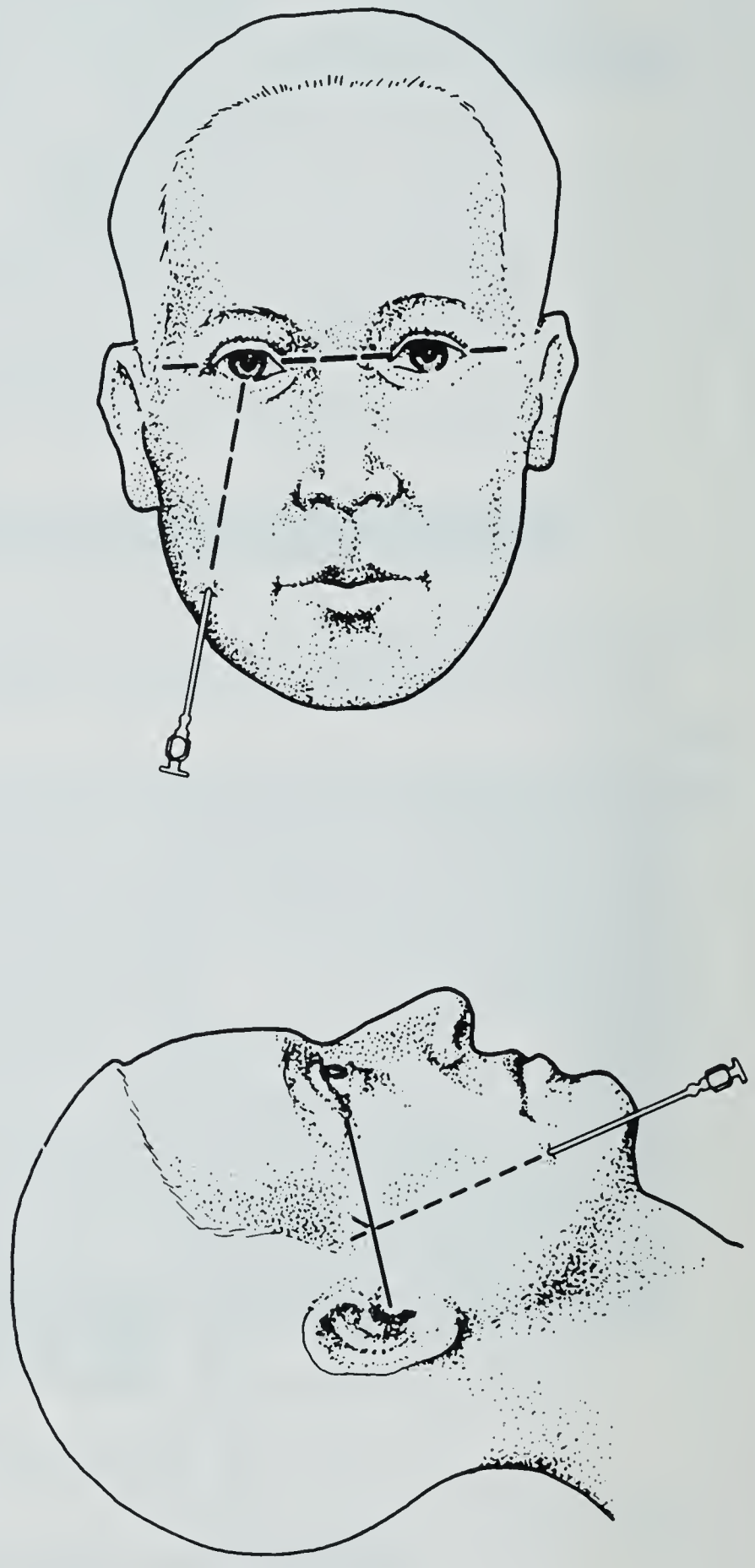

Figure 1. Needle path through cheek to foramen ovale at base of skull.

stimulus is applied to the electrode. This is perceived as a tingling sensation in the face, and allows precise placement of the electrode to involve the portion of the sensory root appropriate to the localization of the patient's pain. A radio-frequency current is then applied to the electrode in increments of ten seconds until satisfactory analgesia to pinprick in the affected area is obtained. In most instances, this requires analgesia of the lower, and sometimes the upper jaw as well — seldom is it necessary to produce analgesia of the

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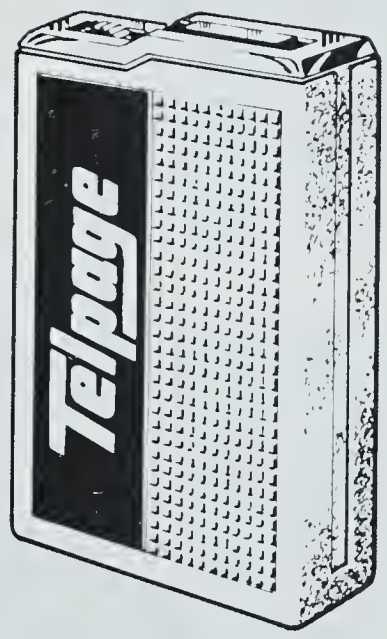

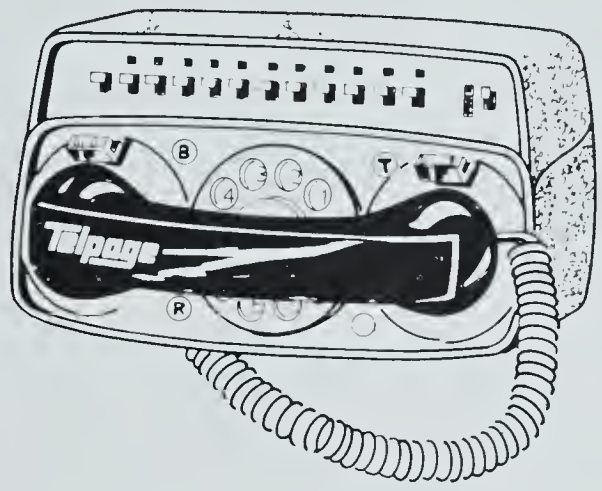

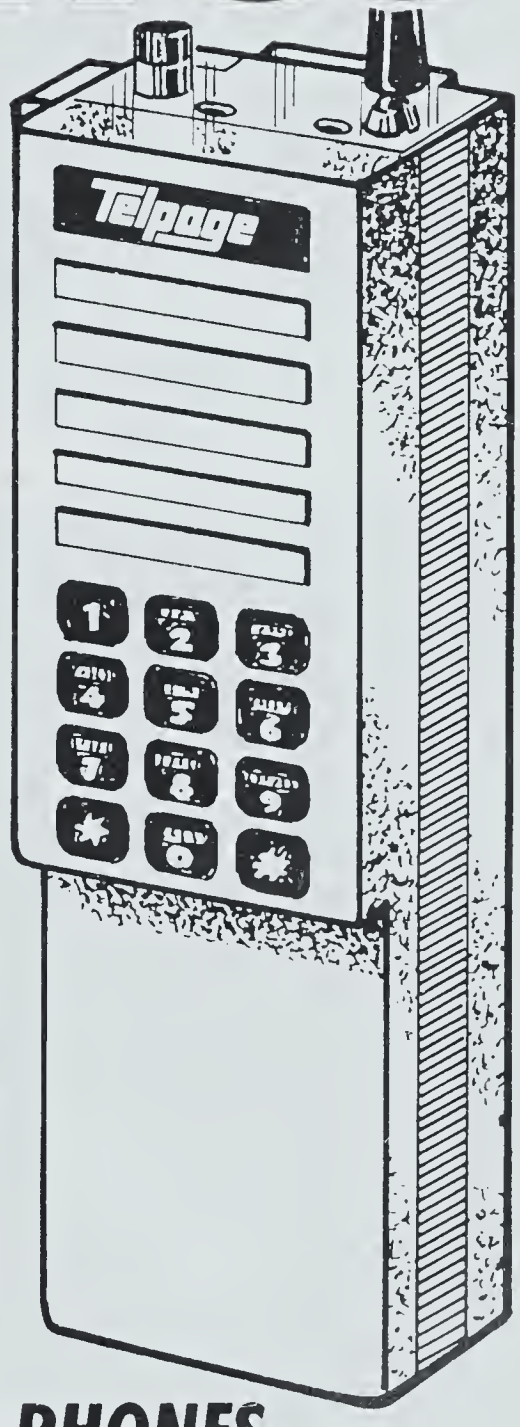

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ophthalmic division. Touch sensation is seldom abolished, but may be reduced to some degree in the affected region. Impairment of motor root function occurs in some instances as manifested by deviation of the jaw on wide opening of the mouth, but this is usually mild and transient.

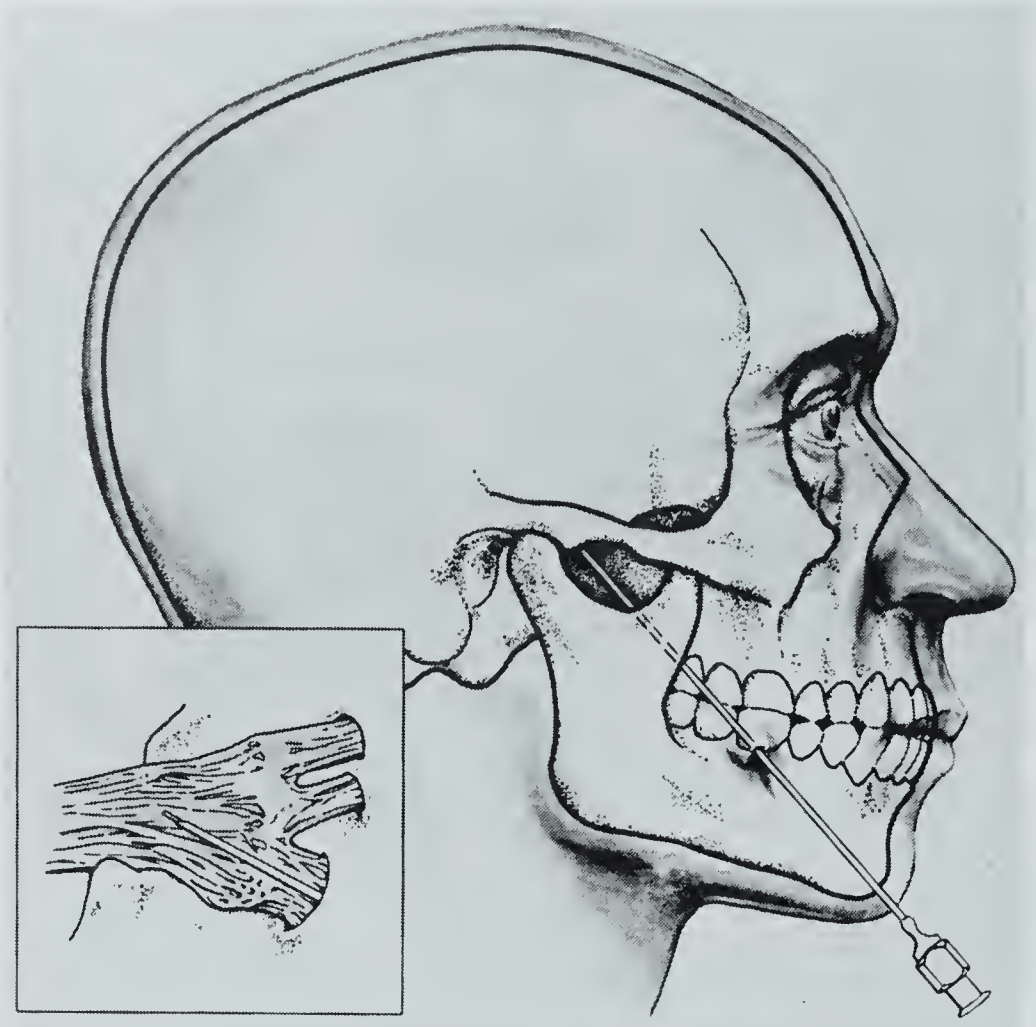

Figure 2. Position of needle and electrode in sensory root of trigeminal nerve.

Case Material

Our experience with this method includes 102 cases done from 1974 to the present. Followup is for all cases included. The results are listed in the following table.

TABLE 1

	Cases
Good pain relief	72
Temporary benefit — later recurrence	20
No improvement	0
Worse	0
Technically unsuccessful	10
Total	102
Complications	0
Mortality	0

In all, 92% experienced relief of excruciating pain, with only partial sensory impairment in most cases. Relief is continuing in 72% with followup as long as 7 years. However, in 20%, there has been recurrence of pain, necessitating repeat radio-frequency rhizotomy in 12 patients, and craniotomy for rhizotomy in 8 patients, all of whom have experienced subsequent relief of pain. In 10 patients, largely in the earlier years of our series, the procedure failed for technical reasons due to inability to get the needle through the foramen ovale and into the ganglion. This is now a very infrequent problem. While the procedure is simple and well tolerated by the patient, it requires technical skill and experience for its best results.

Summary

Percutaneous radio-frequency rhizotomy is effective in control of pain of trigeminal neuralgia in over 90% of cases, with preservation of touch sensation in the face in most cases. There is a 20% recurrence rate in our experience to the present, but the procedure can be repeated and most of the patients with recurrent pain chose to repeat this procedure rather than resort to an intracranial operation. The procedure is well tolerated by the aged and infirm patients, with no major complications and no mortality in our series. In 10% of our series, the procedure could not be completed because of technical difficulty in placement of the needle. This problem has diminished with further experience with the method. Percutaneous radio-frequency rhizotomy is a satisfactory alternative to the intracranial procedures when medical therapy is no longer effective.

The authors wish to thank Kevin Windsor for obtaining and tabulating followup results in this series.

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INDICATIONS AND USAGE SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency.

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WARNINGS The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium; the results from central vagal stimulation could cause bradycardia.

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DRUG ABUSE Drug dependence has not been reported with SU-TON.

OVERDOSAGE Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage. Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION One tablespoonful (15 ml) 3 times a day 20–30 minutes before meals. This drug is not for use in children under 12 years of age.

HOW SUPPLIED Bottles of 473 ml (16 fl. oz.) NDC 0524-1015-16

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Shingles, Herpes, Sex and Mononucleosis

Editor, The Journal:

Several years ago I learned something and thought it was my Christian duty to pass it on to the medical profession. I wrote up the facts in typical Clemmons' style and mailed it to one of the nationally distributed, or even internationally distributed, medical journals.

I later received a call from one of the sweet young girls working for them and she told me that I had a good article they would like to use, but it would have to be redone in proper of style. She suggested *The Elements of Style* by William Strunk, Jr. and E. B. White. She also briefly told me what their particular style is. I was kind and just told her, ''No, thanks,'' and that I didn't have the time.

So I approach you, not with fear, not with any burning desire, but simply with the idea that I may write to you as ''a letter to the editor.'' You know me well. I am not a scientist. I am not a medical writer, and I am too old to try to adapt myself and my writing to a manuscript style required by our various medical journals.

So, consider this a letter to the editor and call it what you will. An appropriate title might be ''Shingles, Herpes, Sex, Kissing, and Mononucleosis.'' I do have something to tell my colleagues in the State of Alabama. I am not particularly worried about the rest of the country, because I have always felt that we practice better medicine here in Alabama than any other place in the world. Of course, I give credit to to the founts of all knowledge where students are taught to become doctors, but I still think the overall caliber of medicine in the State of Alabama is better than any place else.

I one time saw a woman with a trichomonas vaginal infection. At that time I prescribed one Flagyl tablet to be taken three times a day for 10 days. She didn't have a husband, so I didn't prescribe anything for her numerous mates. Anyhow, she took the Flagyl and told me it was remarkable. She was in the habit of having frequent bouts with ''cold sores'' and while taking Flagyl she started to have a cold sore, but it aborted. She had had no more cold sores since she had taken Flagyl some four or five months previously.

Then along the way some place somebody told me that Kutapressin would dry cold sores up more rapidly than anything else, so I tried two or three people on Kutapressin. Then in my country way of thinking, I started treating people with herpes zoster, or ''shingles'' as we call them in Cullman, with Kutapressin and Flagyl.

I don't have any idea why I used both, except that I figured both the Flagyl and Kutapressin might be of value, so the two of them together might work better. I guess this comes from my long time belief that if one is playing baseball and hits a home run, and even though

his father is the umpire, he should touch all the bases and not run any chance of being called out. So I started using Flagyl and Kutapressin to treat cold sores, shingles, and occasionally other diseases that I knew of no cure for. Then along came a rash of youngsters with mononucleosis and I treated them with Kutapressin and Flagyl and they got well.

Years ago when I was in school and later at Charity Hospital, I knew of a disease called herpes progenitalis. I never heard of herpes II until a few years ago. When I heard that herpes II could not be cured, I then thought, "Aha, I must cure some people with herpes II." So I began treating herpes II with Kutapressin and Flagyl and except for one case, I remember no failures at all. This one case was not a failure, but it did recur two or three times and now, to the best of my knowledge, she has had no recurrence for over two years.

This past fall I became more than casually interested in the Cullman High School football team since my son Sam, a tenth grader, and my grandson, Philip, an eleventh grader, are on the same team and both required my constant attendance at practice and games because I had rather watch them than work in my office. Last year, my grandson Philip broke a leg, so he didn't get to play football. This year he was doing very well until he developed a general malaise and just didn't feel well. One of his teammates had been diagnosed as having mononucleosis, so, of course, I had to think about mononucleosis in my grandson Philip.

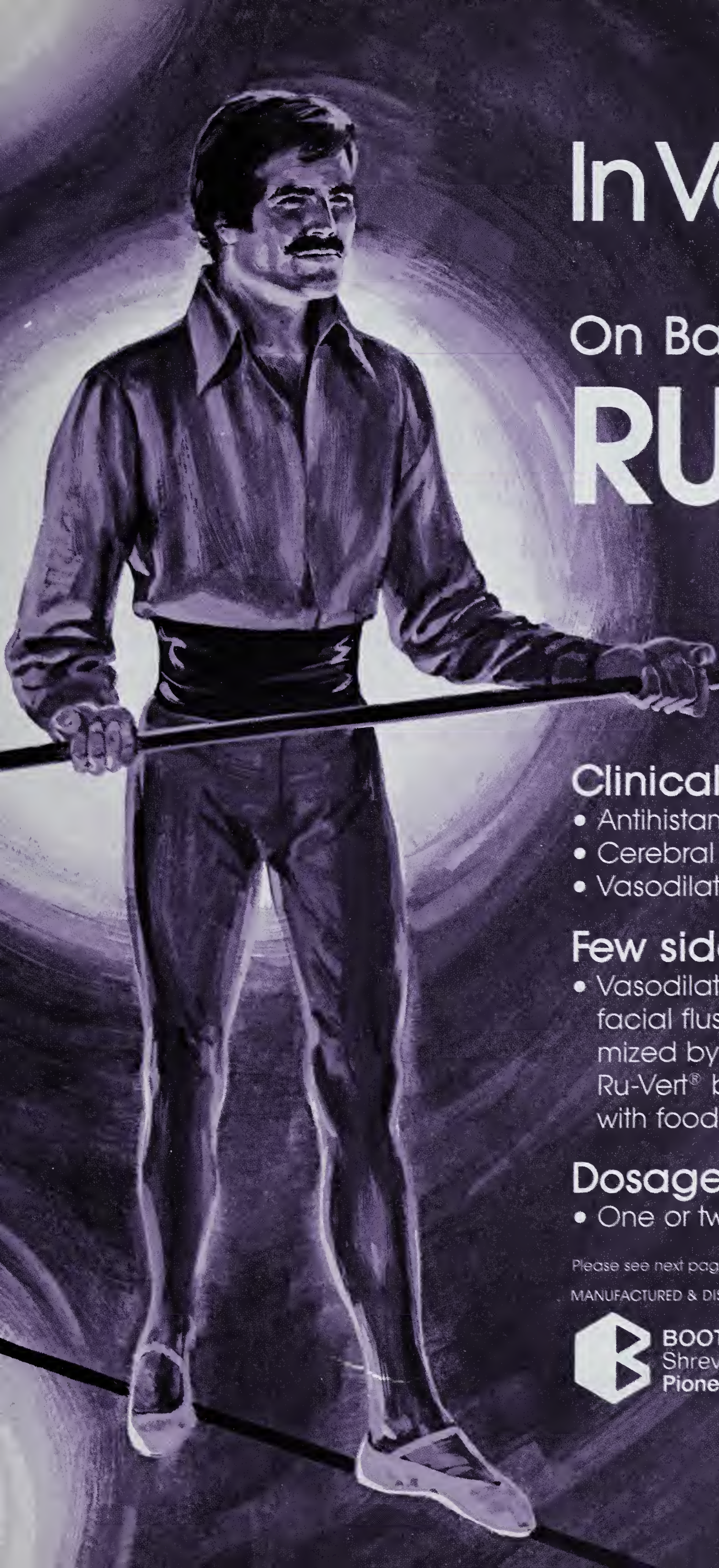
He had a positive test. Since he had some pain over his spleen, I had my good friend, Dr. Walter Brower, do a scan on him and he called me to tell me that Philip's spleen was about four times normal size and he felt the child, by all means, should not be playing football.

I talked to Dr. Bill DeShazo at Tuscaloosa and figured he knew more about football and mononucleosis than anybody else around. He gave me his opinion and said absolutely Philip should not be playing football and that the other boys on the team who had mononucleosis should not be playing football because of the increased possibility of rupture of the spleen.

So I relayed the message to the coach and to parents whom I knew and started my grandson Philip on Flagyl and Kutapressin. About three days later he felt fine. I had his spleen scanned again and it was about half the size it had been. Three or four days later it was scanned again and it was normal.

Walter Brower never did tell me to let Philip play football, but I did and figured that he ran a normal risk of having a ruptured spleen whether it was enlarged or not and if it wasn't enlarged, then I didn't think the risk was increased.

Now this was not Bill DeShazo's thinking, it was mine. Anyhow, he went back to playing football and was successful until he had an ankle injury and was out for the last two games.



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It makes sense now.

Incidentally, I wonder how many of my colleagues have a son and a grandson playing on the same high school football team. I don't know whether this represents an excess of hormones in me or whether it just represents my persistence. Anyhow, it may be a first.

My grandson Philip did get over mono. He got well and played ball. Several other youngsters, either in the families of the ball players or other ball players, got mono and cleared up with Kutapressin and Flagyl. One youngster who was ten or eleven had a positive mono test and I put him on Flagyl without the Kutapressin, because he just absolutely rebelled at the idea of taking any shot.

Three days later, his white count, hemoglobin, and hematocrit were much lower. I discontinued the Flagyl and his blood picture became normal again.

Now all this time during the fall football season, I was trying to come to some conclusions regarding mononucleosis. I talked to the medical directors for the people who make Kutapressin. I also talked to the medical director of the people who make Flagyl.

As a matter of fact, I talked to him some three or four times and when I told him about the depressed white count and hemoglobin on this youngster, who, incidentally, had been playing peewee football in the Park and Recreation program, I also told him I had already discontinued the Flagyl and asked him, "Should I have?" He said, "Absolutely, yes. Leave it off."

Now neither of these medical directors acted at all interested in what I knew about the treatment of mononucleosis and herpes in all its various forms, but I volunteered the information anyway whether they wanted it or not. I had the feeling with them that they thought I just might be trying to get them to hire me or that I was expecting some monetary compensation for my diligence in research.

I thought about the time, many years ago, when I had a Doberman Pinscher who was an outstanding specimen and some woman called me wanting to know if I let him breed other dogs. When I told her I did, she asked, "Well, how much do you charge?" I answered, "Well, we don't charge anything. He just does it for fun."

Of course, she hung up and that was all right. Anyhow, I volunteered the information and let everybody know that I knew something that I thought the rest of the world should know. They didn't want it.

Now, not documented, but absolutely correct is the fact that my grandson Philip cleared up. Incidentally, not only did the size of his spleen go down rather

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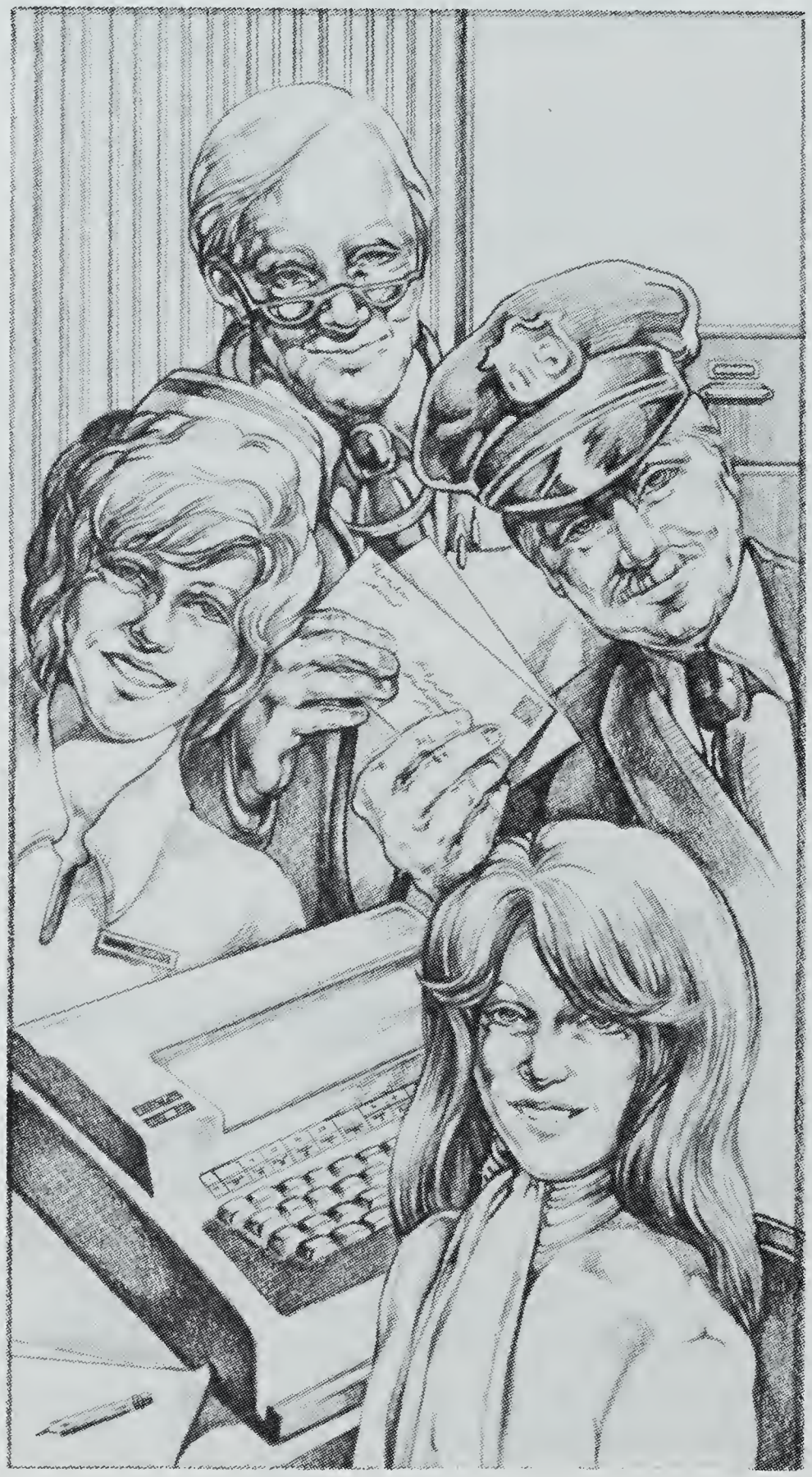

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rapidly, but his test for mononucleosis became negative very shortly.

I don't have any documented proof. I have been too busy watching Pat Dye try to build a football team at Auburn and I have been too busy watching Paul Bryant beat all records, so I don't have time to do research. About the only conclusions I have are that I have seen people with herpes in its various forms and mononucleosis in its various forms (if there are various forms) get well.

Now, what about dosage? I first started using Flagyl in people with trichomonas infections and I usually gave the female 30 tablets to take one three times a day and the male 20 tablets to take one twice a day.

Then I read an article by some Frenchman who said that Flagyl could be given in smaller doses of six tablets to be taken morning and night for one day only.

Then I read about a doctor over in Mississippi who gives massive doses of Flagyl to treat arthritis and apparently is successful. What doses then of Flagyl? I pretty well have settled on Flagyl three times a day for anywhere from 6 to 8 to 10 days.

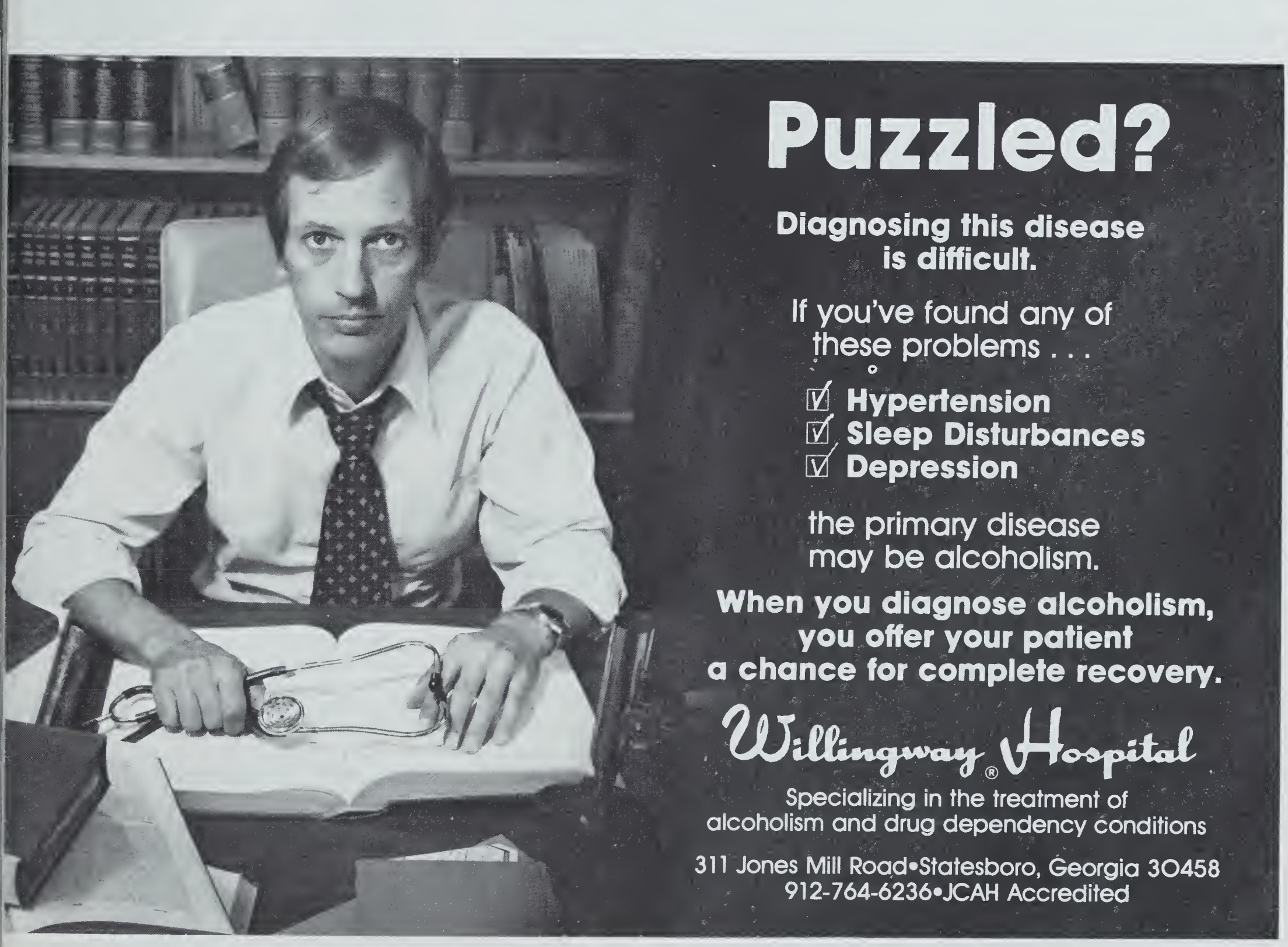
What dosage of Kutapressin? I usually give two cc's of Kutapressin to an adult or young male every day for three or four days, then every other day for another three or four days. Rarely do I give over seven or eight shots.

I am not sure the Kutapressin is essential. I feel that together they work better than either one of them singly.

Incidentally, there is a sign in each of my examining rooms that says, "If you're taking Flagyl, don't drink any booze." I think if one takes Flagyl and drinks booze he'll become nauseated.

So here you have it. Not written as a medical article, not even scientific, except that I have seen some results and I believe that mononucleosis, shingles, cold sores, and herpes II can be cured with Flagyl and Kutapressin in combination. This is not my imagination. It works. I would like for some good scientists to see what the value really is.

LOWELL H. CLEMMONS, SR., M.D.
Cullman, Alabama



Immunization in the Elderly

continued from page 19

these high risk groups.[15] Studies have shown that the pneumococcal vaccines produces antibody levels in up to 80% of vaccines and reduces the rate of pneumococcal pneumonia by 92%.[16] The dose of this vaccine is 0.5 ml. intramuscularly every 3 to 5 years.

In summary, defense mechanisms, infections, antibiotic therapy, and immunizations of the elderly have been examined. It is hoped that with a better understanding of these factors, more effective diagnosis, therapy, and prevention of infectious diseases of the elderly will be obtained.

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President's Page

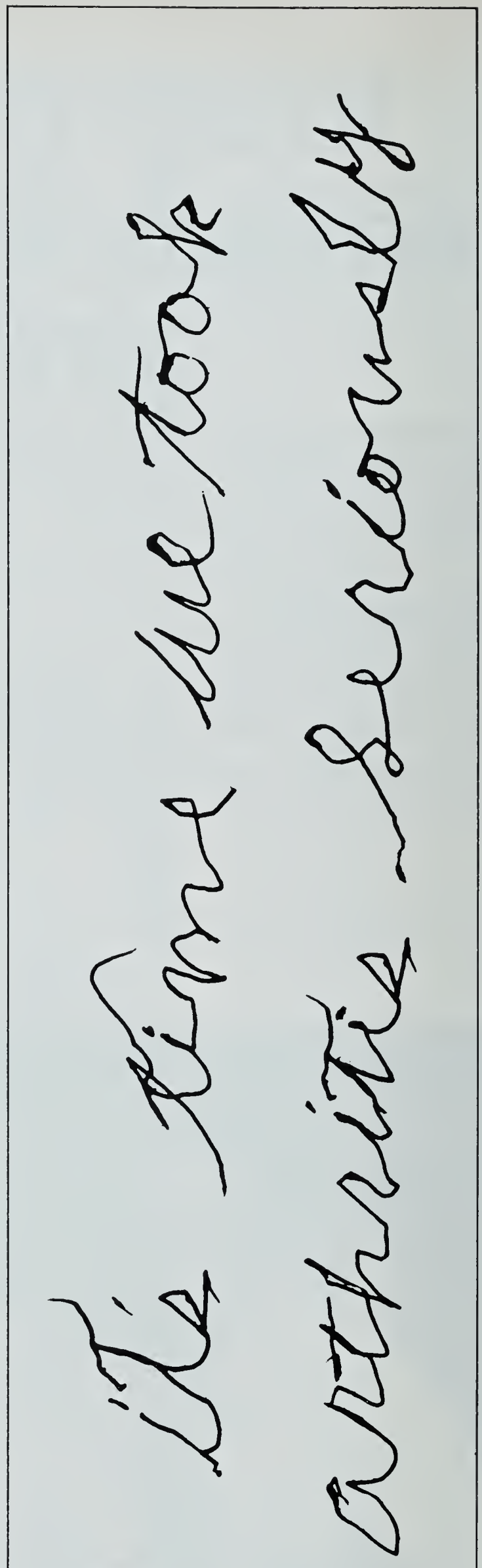
continued from page 4

All physicians will find increasing restrictions and limitations on their practice no matter how hard they may be willing to work. The middle age physician will have difficulty preparing for his retirement years. The older physician will find his retirement delayed because of changes in the practice patterns which prevent his preparation for retirement.

I don't think we have a choice anymore. We have a tremendous stake in seeing that Mr. Reagan's programs survive and are effective. We have an even greater stake in seeing that the health care programs and principles are not altered in a fashion that is detrimental to the health of the nation.

The velvet glove should be still outstretched, but the mailed hand inside had better be well oiled and polished to a bright luster. The voice may still speak softly, but it better speak firmly; and the stick better be finely dusted and cleaned.

Kendall



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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically,* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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J-9043-4 July 1981

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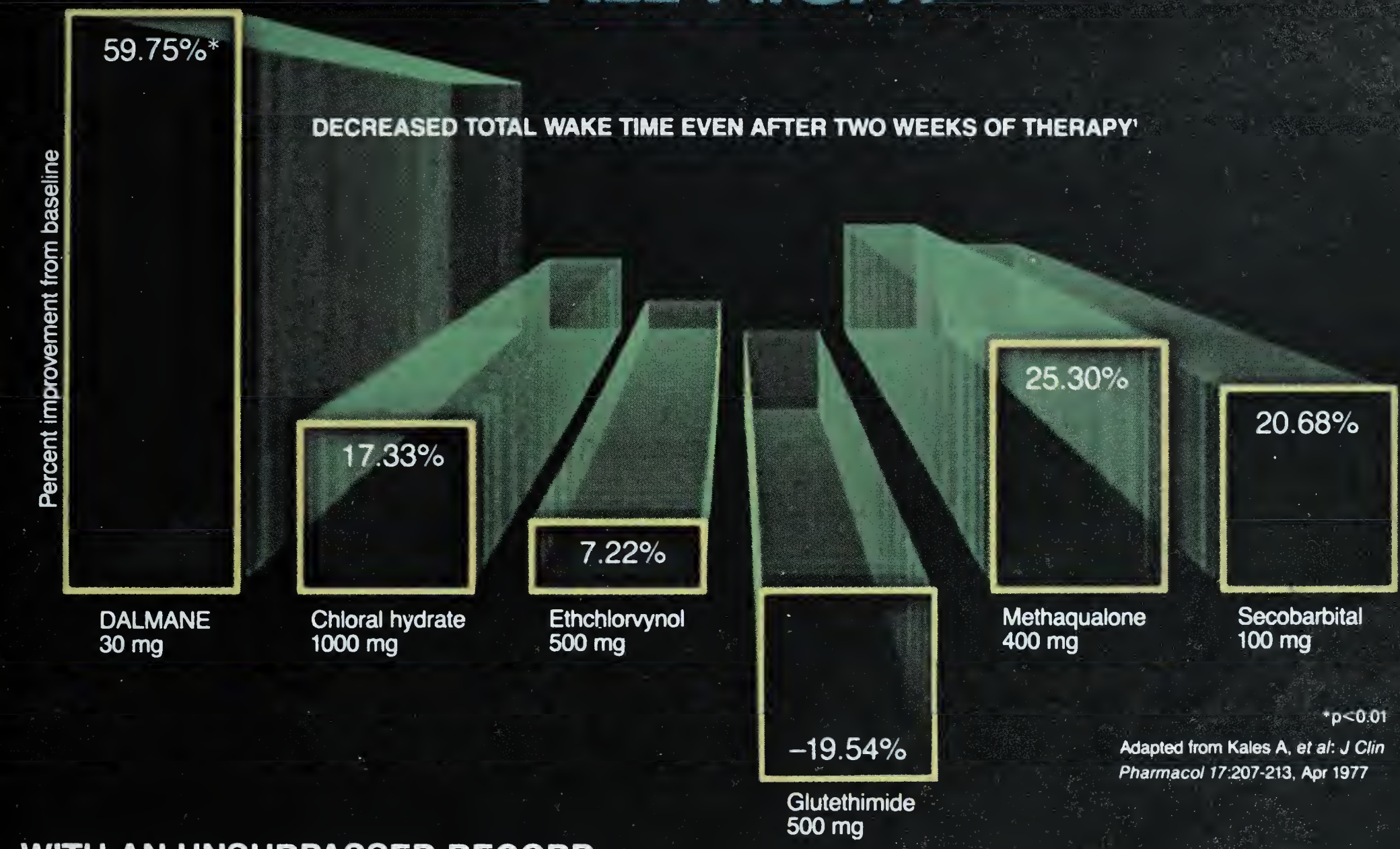

WITH AN UNSURPASSED RECORD OF EFFICACY AND SAFETY

The efficacy of Dalmane (flurazepam HCl/Roche) has been documented in 185 studies involving 9141 patients suffering from one or more of the three major forms of insomnia–difficulty falling asleep, staying asleep and sleeping long enough.[2]

Relative safety was demonstrated in a large study of 2542 hospitalized medical patients. Only 3.1% of these patients reported adverse reactions–predominantly unwanted residual drowsiness. None of the reactions were considered serious by attending physicians.[3]

FOR SLEEP WITHIN 17 MINUTES[2] AND NO WORSENING OF SLEEP ON DISCONTINUATION

Rapid sleep induction, within 17 minutes on average, sets the stage for insomnia relief. And, after discontinuation of Dalmane for periods ranging up to 14 nights, no worsening of sleep compared with baseline was observed.[4]

Should insomnia recur, the patient may require guidance in setting up a regular sleep program to help provide the optimum environment for the onset of natural sleep. If hypnotic therapy is required, it should be given for the shortest time at the lowest effective dose to achieve the desired goal.

Consider other medications the patient may be taking (including alcoholic beverages) and be aware of possible drug interactions. Please note that patients should be treated for underlying physical or psychological factors before therapy with a sleep medication is undertaken.

DALMANE® C-IV

flurazepam HCl/Roche

THE STANDARD OF HYPNOTIC EFFICACY FROM THE LEADER IN SLEEP RESEARCH

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Please see reverse side for a summary of product information.

SLEEP-SPECIFIC
DALMANE® C IV
flurazepam HCl/Roche

One 15-mg capsule *h.s.*–recommended initial dosage for elderly or debilitated patients.
One 30-mg capsule *h.s.*–usual adult dosage
(15 mg may suffice in some patients).

THE STANDARD FOR HYPNOTIC EFFICACY WITH IMPORTANT ADDED BENEFITS

- Well tolerated[2]
- No chemical interference with many commonly ordered laboratory tests, including triglycerides, uric acid, glucose, SGOT, alkaline phosphatase and total protein[5,6] (See adverse reactions section of complete product information.)
- Compatible with chronic warfarin therapy; no unacceptable fluctuation in prothrombin time reported[7,8]

UNLIKE NONSPECIFIC MEDICATIONS USED FOR SLEEP

Tricyclic antidepressants

–which are *not* sleep specific,[9] yet are sometimes used in nondepressed patients for sleep

–which can cause transient insomnia in the elderly[10]

–which can require careful monitoring in cardiovascular patients[10]

–which have strong anticholinergic effects[10]

Antihistamines

–which are *not* reliable sleep-inducing agents[11]

–which may produce stimulation instead[11]

–which have anticholinergic effects[11]

Major tranquilizers

–whose side effects may be troublesome for nonpsychotic patients[12]

–where tolerance for sedation appears rapidly[12]

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.[4]

References: **1.** Kales A, *et al*: *J Clin Pharmacol 17*:207-213, Apr 1977 **2.** Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **3.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977 **4.** Kales A, *et al*. *Clin Pharmacol Ther 18*:356-363, Sep 1975 **5.** Moore JD, Weissman L: *J Clin Pharmacol 16*:241-244, May-Jun 1976 **6.** Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **7.** Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO New York, Raven Press, 1973, pp. 641-646 **8.** Warfarin Study: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ **9.** Baldessarini RJ: Drugs and the treatment of psychiatric disorders, chap. 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co Inc., 1980, pp. 391-447 **10.** Cole JO, Davis JM: Antidepressant drugs, chap. 31 2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2. Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1941-1956 **11.** Douglas WW: Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap. 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6. New York, Macmillan Publishing Co. Inc., 1980, pp. 609-646 **12.** Davis JM, Cole JO: Antipsychotic drugs, chap 31 1, in *Comprehensive Textbook of Psychiatry/II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2 Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp. 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.
Adults: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients*: 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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President, A-MASA

Physician, Heal Thyself

"It's a good idea to take an interest in the future — that's where you'll spend the rest of your life."

Dr. Jones, when was your last physical examination? You say you meant to have one last year when you were having a little chest pain but you were just too busy at that time.

Besides, Dr. Smith, your associate would probably think you were a hypochondriac. You could tell if there was anything bad wrong anyway, right?

Patients seems to label their doctors as Superman. The physician and his family evidently share this illusion. He thinks there is no way that *He, The Physician* could be subject to the same illnesses the patients suffer. He should be immune to human frailties. Therefore, all symptoms are ignored until the illness becomes intolerable or incapacitating.

The physician's wife seems to have just as much difficulty making an appointment for a regular physical examination. Her reasons include: the doctor is too good a friend; she hates to take advantage of professional courtesy, etc. There are infinite ways for us all to procrastinate.

Both the AMA and the AMA Auxiliary are committed to the field of preventive medicine. To effectively teach preventive medicine, we must also be willing to practice it. This includes losing excess weight, stopping smoking, regular exercise, putting controls on alcohol consumption, and a regular physical examination.

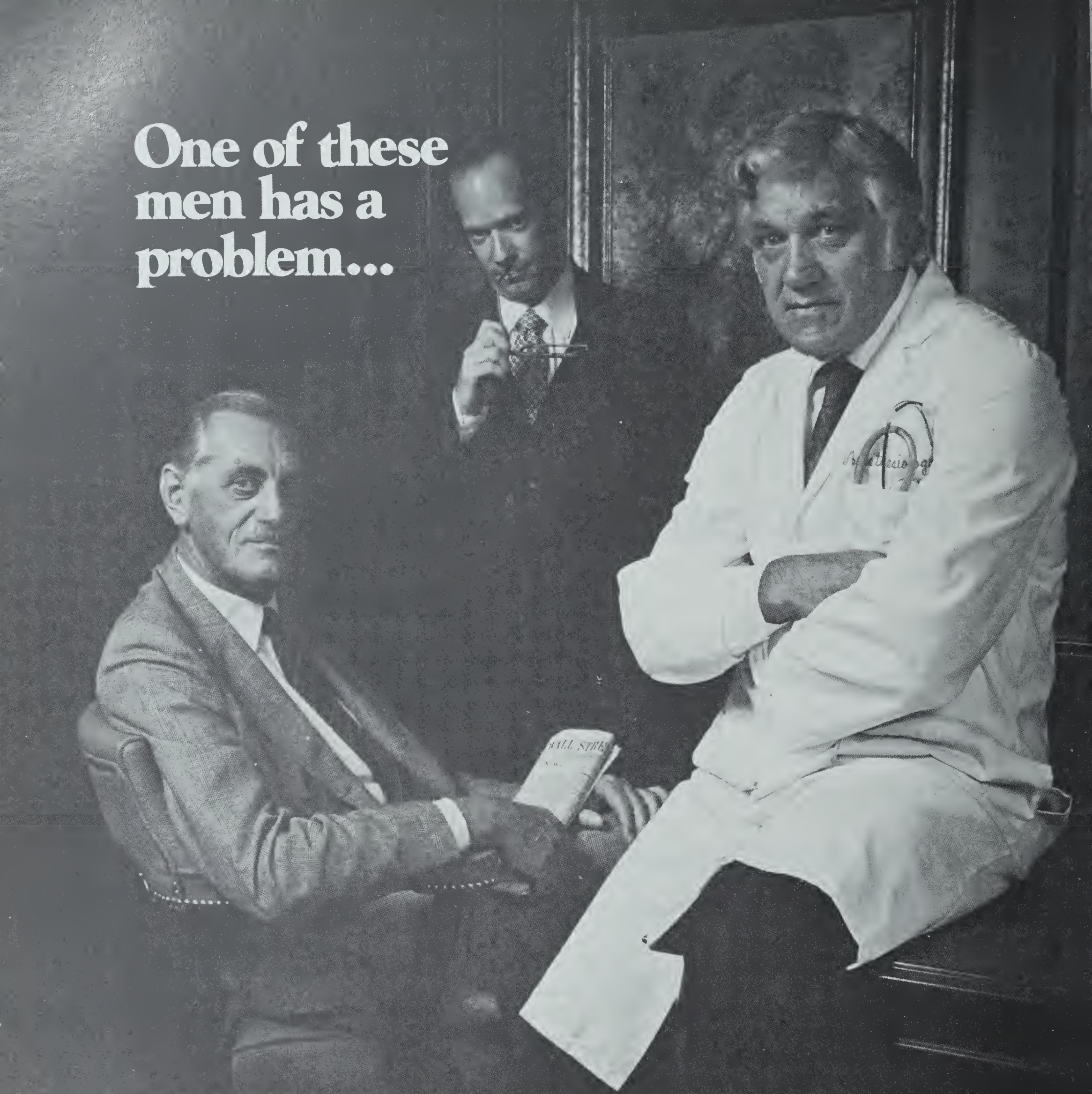
We all know the advice we give to our friends and patients. We should give no excuses we would not be willing to accept.

Maybe it would be a good idea to have a National Physician's Check-Up Week.

"Your body is the baggage you must carry through life. The more excess baggage the shorter the trip." — Arnold H. Glasow

Mary Julia Lee

One of these men has a problem...



and so do his family and colleagues.

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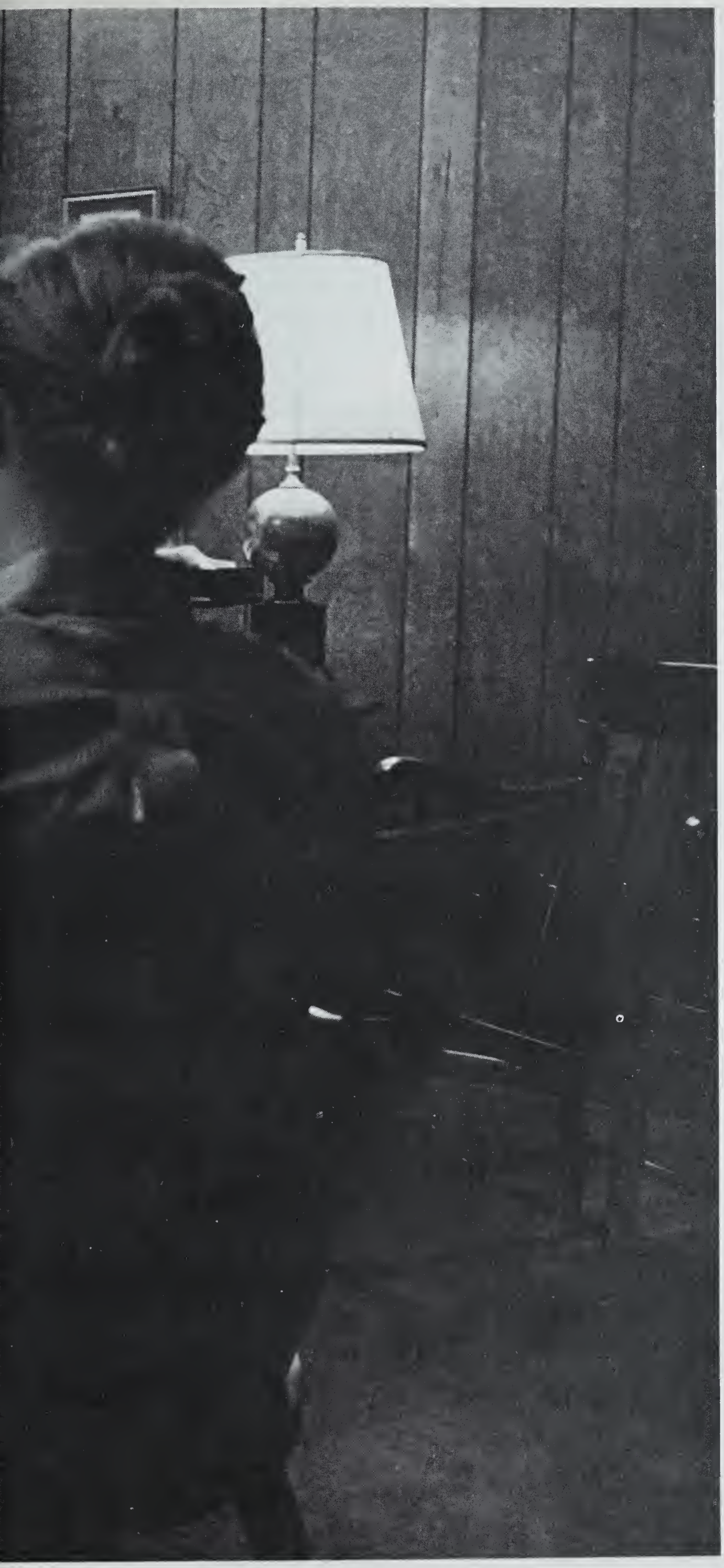

Ronald E. Henderson, M.D., 45, who will take office as MASA President next month in Huntsville, will be featured in a cover story in the April Journal.

In it, Dr. Henderson makes clear his plans to run for the presidency of the American Medical Association and his time-table for that bid.

The picture at left, taken in Dr. Henderson's office, symbolizes what to him is the most vital duty incumbent on physicians today: to return to their former role as the patient's advocate.

In a time of fragmentation and specialization demanded by the growth of knowledge and skills, this role has been abdicated, Dr. Henderson believes, and must be restored.

In some hospitals in university settings, he says, the vacuum has been filled by hired staff members known as Patient Advocates, similar to ombudsmen.

That is not enough, Dr. Henderson believes: the doctor must be, as he once was, the patient's advocate in all matters affecting his/her health and well being.

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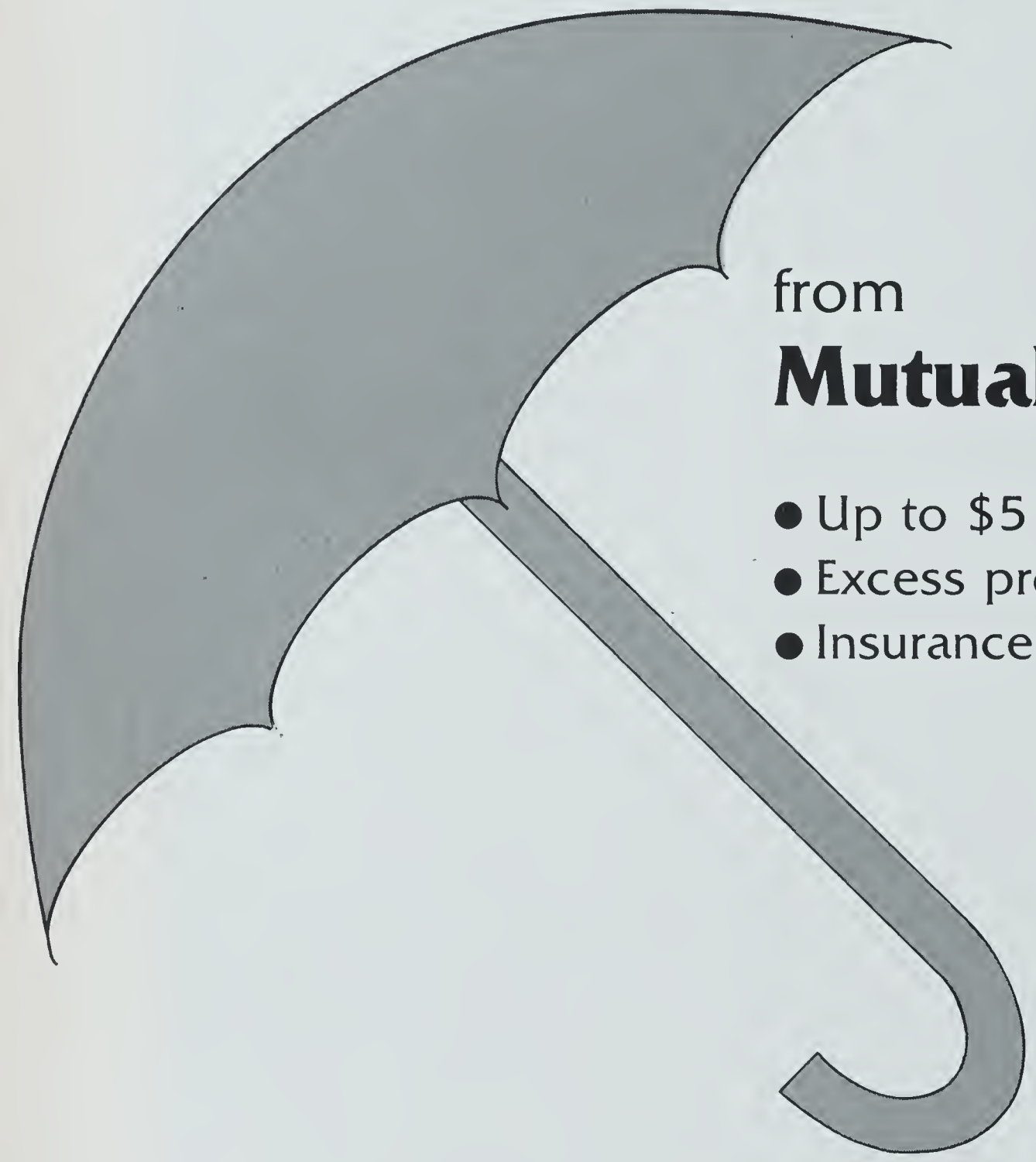

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7:00 p.m.
Dinner with Alabama Congressional Delegation

Sunday, March 28, 1982

8:00 a.m.
Breakfast

9:00 a.m.
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"When I saw a cripple, I'd stop stark still and walk across the street."

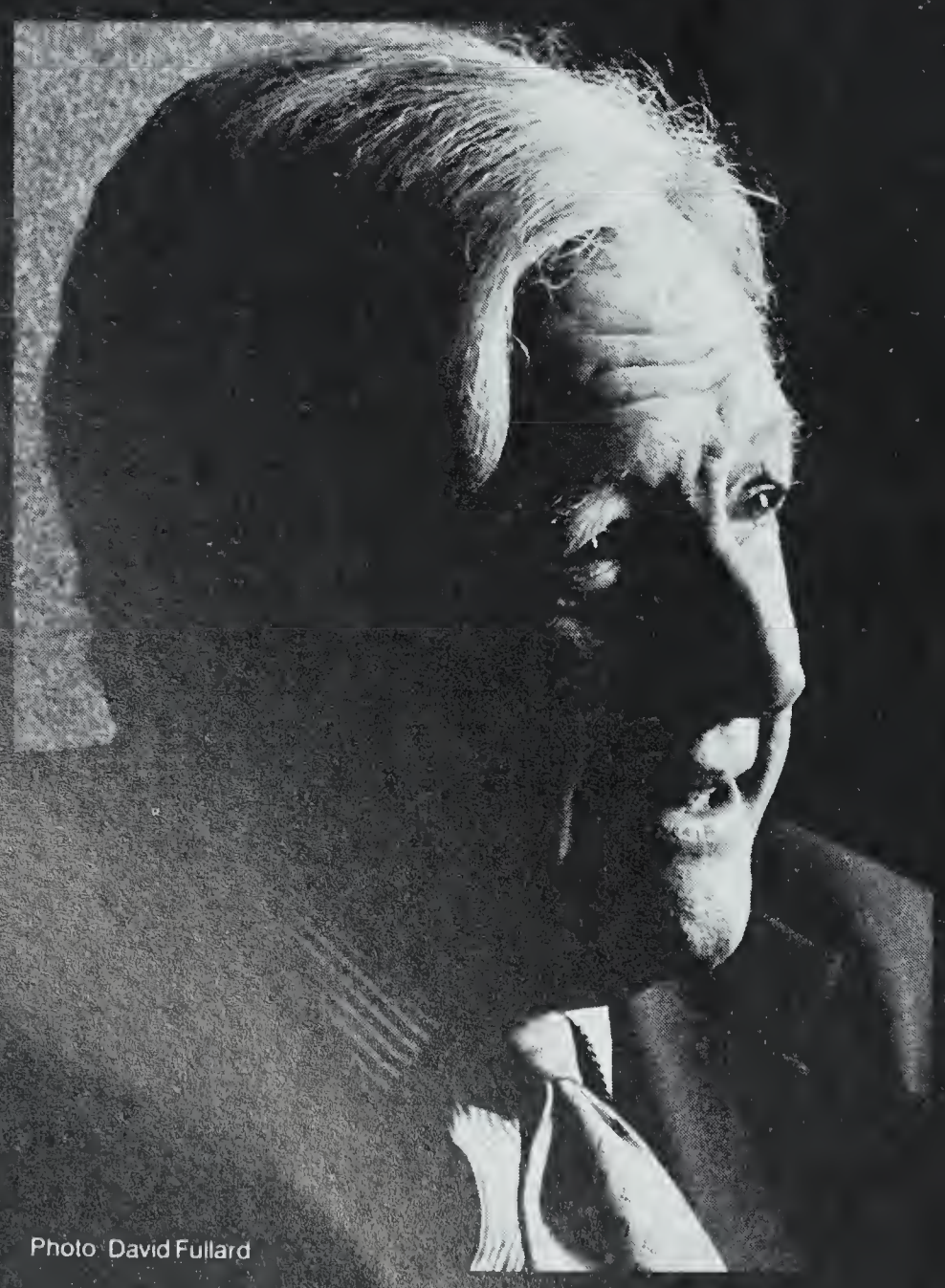

Photo David Fullard

In explaining that reaction, Dr. Colter Rule, a practicing psychiatrist says, "I guess it was a mirror and I was unacceptable to myself."

Dr. Rule was disabled by polio as a child. At five he was sent to an institution that was hundreds of miles from his home. That year away—which he remembers as more like ten years—resulted in a permanent emotional severance from his family. "The way my family responded made me feel it would have been better if I hadn't been born. At the institution, I perfected a superficial charm to get attention and approval. But inside there was an enormous rage that stayed with me for years. As an example of my negativism, when members of my family stressed that it was lucky I could play the piano, since I couldn't dance, that was the last time I touched the piano.

"When I became a doctor I thought, now, I will be dealing with the sick and I won't have to deal with myself. That's why it took me such a long time to identify or get involved with the problems of the disabled."

Dr. Colter Rule sums it up in these words today, "We must work and learn together. After all, an abused child can be more seriously disabled than someone who has difficulty with coordination. We must stop treating any disabled person as a loser and begin to build gateways for them through which they can join the rest of the world."

President's Committee on
Employment of the Handicapped
Washington, D.C. 20210

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succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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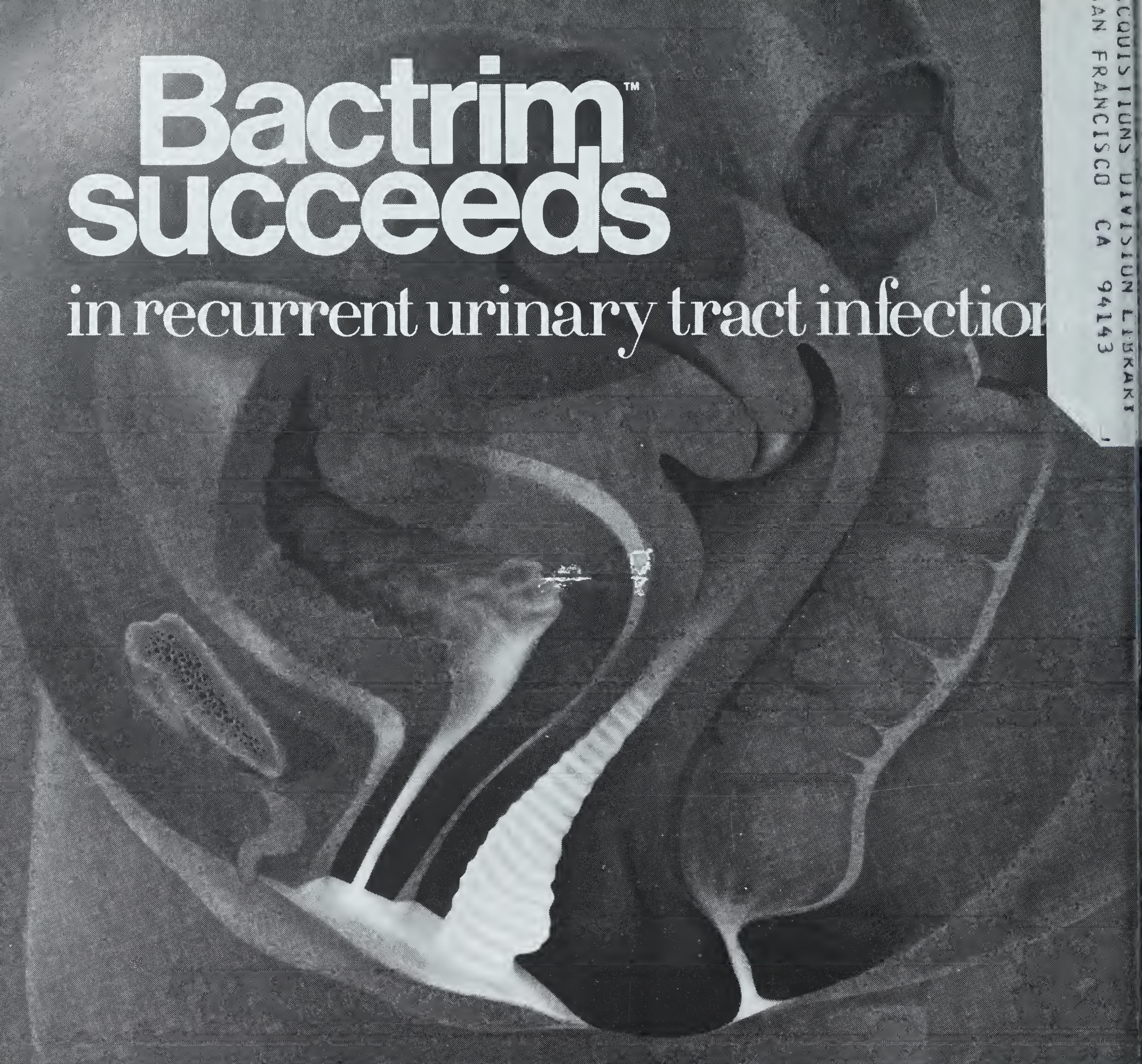

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1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980..**2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

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VOL. 51, NO. 10 APRIL, 1982

MASA's New President: Dr. Henderson Run?

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ONE OF THE VITAL SIGNS OF ANXIOUS DEPRESSION:

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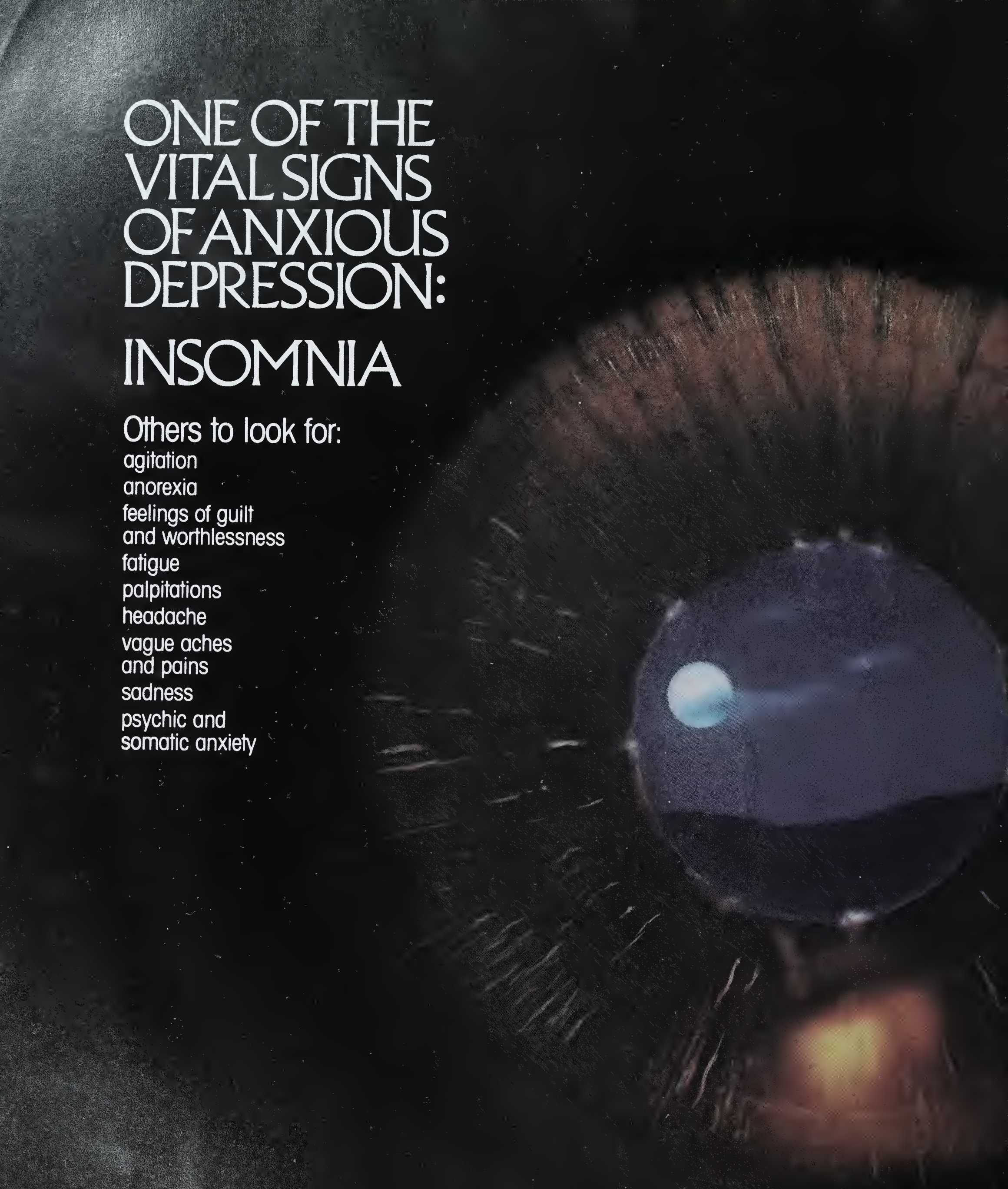

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Neuralagic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Antichalinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematalagic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
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Endacrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
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Auxiliary 51
1981-1982

This Month's Cover

At Twin Valley Farms in Autauga County, Ronald E. Henderson, M.D., the sometime cattleman, looks to embryonic transplants to build his heard on the 1,600 acres he bought near the family farm on which he was raised. When a near-fatal automobile accident forced the 1982-83 President of MASA to reflect on his life, he made some fundamental decisions about its direction. **Page 8.**

EXECUTIVE DIRECTOR

Tigers, Back to Back

J. Kendall Black, Jr., M.D., now ending his MASA presidency, has probably traveled more miles and made more speeches than any president in the history of the Association.

His energetic dedication to spreading the medical word would leave a man half his age breathless. Plainly, Dr. Black had no intention of being a titular President. He had been down in the trenches with the troops, the working clinicians, hearing their thoughts and woes and passing around such solace as he could muster.

Dr. Black has appealed to young and old physicians alike, rural and urban, trying to convince them all, that (1) the free practice of medicine can be saved if (2) the efforts of all are joined in unity of purpose for the common cause.

Far from being a solemn Cassandra, a prophet of gloom and doom, Dr. Black has sallied forth all over the state carrying an optimistic rallying cry: ''Yes, the enemy is real, but he is not 9 feet tall and we can lick him if we stand our ground and fight every inch of the way.''

Dr. Black has an infectious optimism about him, an engaging sense of humor of the kind that has always seen this country through in its darkest hours. In fact, his way of combining a deadly serious message with a mordant joke or two about the Feds (or himself) makes the bitter tonic palatable. He has a way of taking the current threats and perils and making them look like choice targets of opportunity, challenges to be met rather than demons to flee.

He is truly an inspired leader and members owe him much for dashing around the state exhorting all of you not to weaken in the struggle.

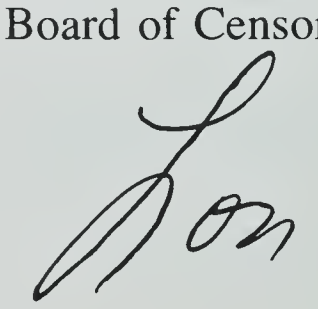
Happily for the Association, Dr. Black's successor this month in Huntsville is another already battle-seasoned leader, Ronald E. Henderson, Jr., M.D. Dr. Henderson yields to no man in his knowledge and his tenacity. He deplores the defeatists who say the war is lost, that the private practice of medicine is doomed beyond hope.

Dr. Henderson's presidential theme will be ''patient advocacy,'' his belief that only the physician can speak for the patient, that this is essential if medicine is to survive with anything like the grandeur that has made it the envy of the world.

Compassionate and tender to his patients, Dr. Henderson is an awesome avenger against all who would dilute or destroy the physician's timeless role. That youthful face and those boyish good looks belie the combatant he is when faced with medicine's enemies, which are legion.

All of which is to say that you are being well served by a succession of superior presidents as the most visible embodiment of an outstanding, highly informed and conscientious Board of Censors.

S. Lon Conner



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PRESIDENT'S PAGE

What Have You Done for Me Lately?

J. Kendall Black, Jr., M.D.
President

In my travels around this state the past two years I am often confronted with the question regarding membership in the AMA and occasionally with the question regarding membership in the Medical Association of the State of Alabama. The basic thrust of these questions seem to be: What's in it for me? And the next question that almost follows without its being asked is: What have you done for me lately?

To me the answer to these questions should jump out at each and every physician in these United States: you can't afford NOT to be a member!

As an individual practicing physician, you have neither the time, the expertise, nor the money to evaluate the many thrusts that are brought to bear upon your practice each day. In the first place the myriad of rules and regulations that are being published with regard to health care are enough to overwhelm any one person's reading abilities, much less a practicing physician.

In the state of Alabama alone there are over 200 bills presented in the legislature each year that bear some relationship to our profession or the allied health professionals. These bills must be reviewed for accuracy of language, legality of presentation, as well as analyzed for their impact on the practice of medicine in the state of Alabama.

You simply don't have that kind of time. If you did have that kind of time, you really don't want to spend that kind of money just to get the copies of the bills. They don't give them away free, you know.

Well let's suppose you had the time, the money, and inclination to get copies of all these bills and read them and analyze them. Then if you want to make any impact with regard to any one of these bills, you've got to show up at the Legislature every single day until that bill is heard in committee or heard on the floor. You have got to discuss it with the Legislators and the Senators, try to make them see it your way, try to make the necessary changes in the bills so that the impact is not detrimental to the practice of medicine and the health of the people of the state of Alabama.

To put it bluntly, you've got to lobby for your bill in order for it to be passed.

Let's suppose though you've had the time, spent the money, exerted the effort and been successful in the lobbying to see that the bill is passed, or perhaps the bill was not passed. Then you've got to see that the necessary rules and regulations and activities are carried out so that it impacts correctly on the practice of medicine in the state of Alabama. So it's expenditure of that time, exertion of that effort, and utilization of your dues money that the Medical Association of the State of Alabama does for you in just one area.

At the national level — agree with them all the time, or not, and I'm sure no one ever does — the American Medical Association is still recognized as speaking for

continued on page 52

Thanks For The Memories

This column is my swan song as your 1981-82 President, an honor I shall forever cherish. For more than a century, in unbroken succession, Alabama physicians have been served by a constant line of officers elected as their stewards. The founders of the Association, in their wisdom, built this continuity into the system.

My successor, Ronald E. Henderson, M.D., is knowledgeable, dedicated, and concerned. He has already served you for many years in a number of capacities and will, I know, keep us moving toward the common objective we all share: patient care and professionalism of the highest order. I commend Dr. Henderson to your attention. You will find Bill McDonald's profile about him on Page 8.

What Makes Dr. Henderson Run?

William H. McDonald

"If by fate anyone means the will or power of God, let him keep his meaning but mend his language: for fate commonly means a necessary process which will have its way apart from the will of God and of men."

—St. Augustine, A.D. 427

Twelve days before Christmas 1974, Ronald E. Henderson, M.D., awoke in the ICU, not knowing how he got there or what was wrong with him.

He had no memory then, and has none today, of the exploding steel of the collision two days earlier, Dec. 11, at a dark and rainswept intersection as he sped to the hospital to answer a night emergency — third trimester bleeding in one of his patients.

What he does know he learned later: that the automobile that smashed into the left door of his little 240 Z sports car crushed his pelvis, fractured his femur in three places and came within an ace of ending the short, happy life of Ronald E. Henderson, M.D., at age 37.

He was not to leave the ICU until New Year's Eve, nor to leave the hospital until Jan. 16. Although he was to return to his busy Ob-Gyn practice a week after that, he did so by the grace of an Ironsides motorized wheelchair. For three months he delivered babies and performed surgery supported by a walker that had been draped in sterile linen at the scrub sink.

He was not to walk unassisted again until June.

Lying in the hospital, unable to turn, shave or comb his hair, he learned the meaning of total dependence for the first time in a life marked by uncommon independence. He learned the agony of waiting 30 minutes for a bed pan when he needed it then. He learned to reach out to those doctors and nurses whose empathy he felt. Not all had it.

Experiencing Helplessness

He had never missed a day from work or play in his life because of illness and thought he was some tough cookie. He learned the frailty and helplessness of illness and suffering. He learned the paramount importance of bedside nursing. Little things. Like placing water within easy reach. Back rubs. Clean sheets.

But most of all, empathy — the invisible radiations from those doctors and nurses who could identify with his predicament — not his illness so much as his *predicament*. Sympathy he could do without; he needed understanding.

The episode was an important turning point for Dr. Henderson — with all that time to read and think, understanding the truth of what Seneca meant when he wrote 2,000 years ago that "fate leads the willing, and drags along those who hang back."

The accident and his recovery from it solidified his belief in a concept that will be the theme of his 1982-83 MASA presidency — patient advocacy. It is preposterous, Dr. Henderson believes, that some hospitals have actually hired lay people called "Patient Advocates." Only the physician can perform that role, he believes, fearing that many have abdicated it.

The long, painful experience had other effects on him as well. What would he do with the rest of a life that had been spared?

"In a funny sort of way, it gave me confidence. Up until that time I thought I was tough. I knew that I was a little bit different from some people, and I hope that doesn't sound too egocentric.

"Now I know I can stand a challenge. This experience gave me confidence I didn't have, but thought I had. It took some of the brashness out of me. Not all of

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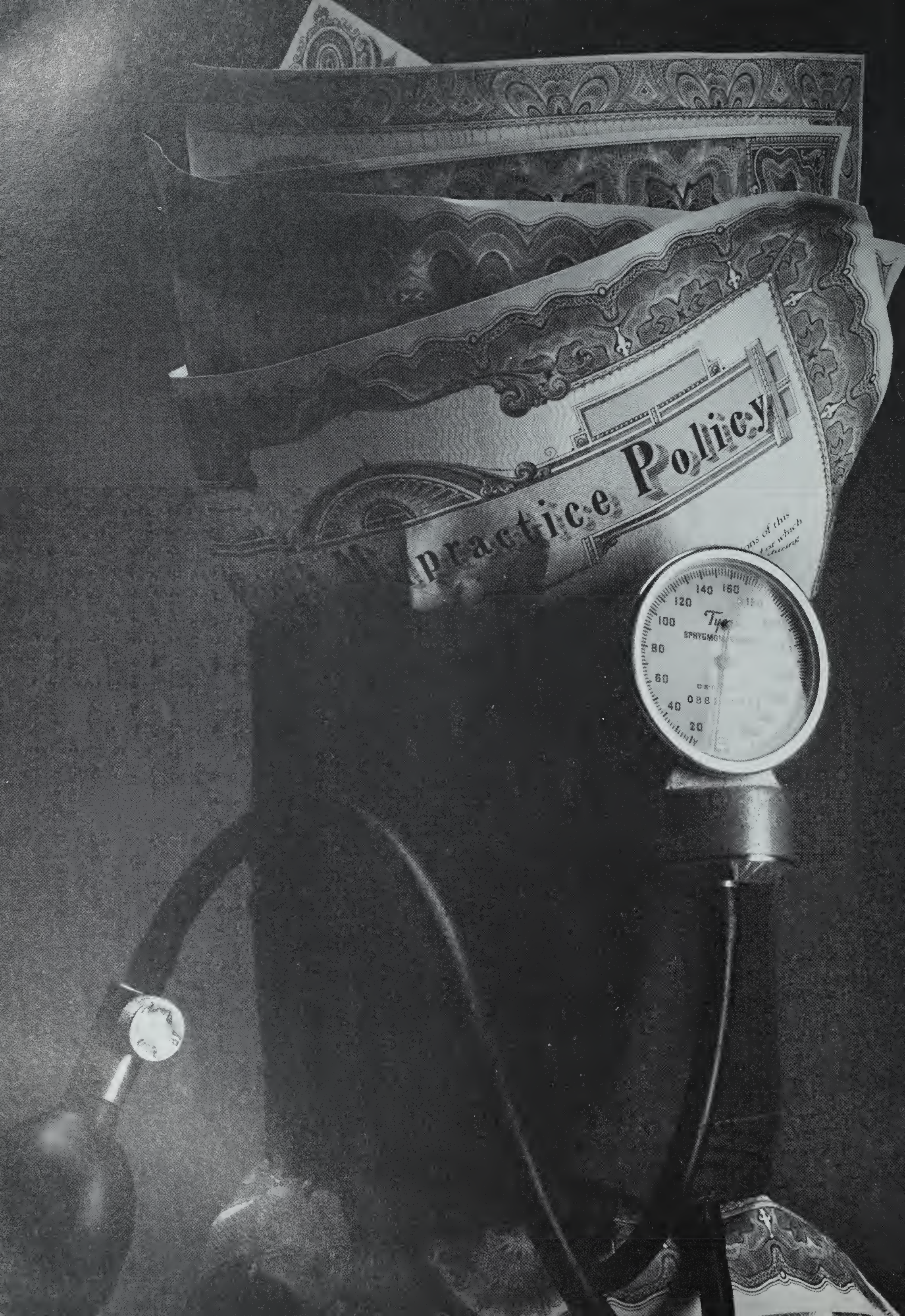
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it, maybe, but some of it. It was a humbling experience.

"I don't know all of how it affected me as an individual, because I am probably not objective enough to know. But of one thing I am certain: it changed my approach to the patient.

"I had always felt that the physician has to be the patient's advocate. Now I know it. It is something that most doctors don't understand: the patient has to have a spokesman. Only his doctor can fill that role. No one else has the training, no one else has the duty and responsibility. . . . "

Lost Concept

Patient advocacy is not a new concept, but a lost one, Dr. Henderson believes. It faded when doctors became too busy, when medicine became fractionalized. What once was second nature to physicians has now become a burden many of them shirk, he believes.

The trauma of a broken body had other effects on him that he finds difficulty even now articulating:

" . . . This happened at Christmastime . . . I had small children, 12, 10 and 7 at the time. . . . My wife was carrying home from the hospital A&P grocery sacks full of get-well cards. I remember I got 311 cards in one day. I had friends, physician friends, very busy, who would drive 100 miles to see me. . . .

" . . . It was a moving thing . . . I still get all choked up when I think about it. . . . "

The profoundly emotional experience thrust him into reflecting on his life, how and why it was spared, and what he intended to do with the balance of it. He developed time frames and flow charts lying there in the hospital. While he is not ready to reveal all of his decisions, he has gone public with one aspiration:

He has announced his decision to seek the presidency of the American Medical Association; he has given himself 12 years to achieve that objective.

Question: Is it prestige, glory, you seek, or what?

"I like to believe it's more than that, but it is that too. We all want recognition. I call it romance, in the largest sense. Romance can mean boy and girl, of course, and we all go through that. But romance can also mean wanting something very badly, achieving it and fulfilling that desire. Doing something well and knowing you are doing it well.

"*You* feel it, don't you? You're thinking how this will look in print when you shape and arrange it.

"If my mother and father taught me one thing well, back on the 116-acre farm in Autauga County that I grew up on, it was this: Whatever you do, always do your best. No matter what it is, make it the best. They hammered that into me, and I have tried to live by it."

Question: All right, then, Dr. Henderson, it is the year 1995, or thereabouts. You have achieved your objective as president of AMA, a heady experience. But now your term is over. You have returned to Birmingham. Is that all? What now?

Sitting there in his comfortable office, tastefully appointed in what can best be described as Americanized Oriental, or Orientalized American, he fingers the collar of his scrub suit, looks at the remains of his lunch on his desk, moves the empty Sun-Maid raisin box a tad while he marshals his thoughts, and begins talking again, slowly at first, then picking up speed. You know by now what follows will be preface to a position statement:

"I was coming back from a Reference Committee F meeting with the AMA Board of Trustees in Chicago. [He is chairman of that committee this year.] Over North Tennessee we hit a thunderstorm. It was throwing that 727 around everywhere all over the sky. And I wondered: What in the hell am I doing here? I could be home in my easy chair with my paper, with my slippers on . . . !

"Sometimes I do wonder what I'm doing but most of the time I think I have a real sense, a calling, to repay what society has done for me.

"As you know, I came from a rural background — solid, salt-of-the-earth people. Before me there was one cousin, on both sides of the family, that had a college education. One cousin. Then my brothers that followed, and some later.

"All of them gave me a leg up. I stood on their shoulders. I have been very fortunate and I have a deep need to pay some civic rent. And that's not just [expletive deleted]. I really want to have an impact. I want to give something back to society. . . . "

Question: But you have already, haven't you? And back to the question, what happens in 1995, assuming that objective has been achieved. Most people would see the presidency of AMA as a terminal ambition for a physician. Obviously you don't see it that way. It's not just the glory you want, but the chance to be of service, to get your message across to a larger audience. Then what?

"I am not sure yet. I think something out there is much different and much bigger than the presidency of the AMA for me. Whether it involves public service, a management job somewhere, I don't know. . . . "

An Eye On Washington?

Question: You mentioned public service. Might that involve national affairs, politics, Congress, the United States Senate? You don't rule out any of these?

Dr. Henderson shakes his head slowly. The raisin box requires his undivided attention for a moment. Then:

"I think there is a real need for professions other than law at the national level — farmers, businessmen, doctors.

"I think it's time the pendulum swings back away from the law and that some of the other professions — and businessmen and farmers — become involved. Think of all the doctors who signed the Declaration of

Independence; of all the farmers who helped found the Republic.

"It is difficult of course for a professional man to make the transition, the sacrifice, because it's not a lateral move. In compensation and time commitment, it is definitely not a lateral move. . . . "

But the light in his eye is not illumined by that empty Sun-Maid box. It's a familiar light to one who has spent a professional lifetime observing its flicker in men who feel they have been tapped by destiny to lead, to carry their message, to fight for their convictions, to enter their ideas in the open lists and stand or fall on their merit.

Ron Henderson first saw the light of day on July 28, 1937 in Prattville, Alabama. His father and mother brought him up under strict rules of personal accountability. They urged him, as did his friends and teachers, to enter one of the professions, but it was not until the 11th grade that he was sure he wanted to be a physician.

His parents were pleased. His father had been in the top of his Sidney Lanier High School (Montgomery) graduating class of 1929 but could not afford college.

"This was a generational tragedy," Dr. Henderson recalls. "He graduated the year of the stock market crash and many like him had no hope of higher education."

They worked to provide hope for the next generation.

Dr. Newton, Benefactor

Money was still short. Ron Henderson had to borrow and work at summer jobs to make his way through college and medical school. One summer he came home without any prospect of work and stopped by the office of the kindly, respected physician who had been his inspiration, Dr. George Newton. Before even going home, Henderson carried his suitcase to Dr. Newton's office and asked to see the doctor. He wanted a job.

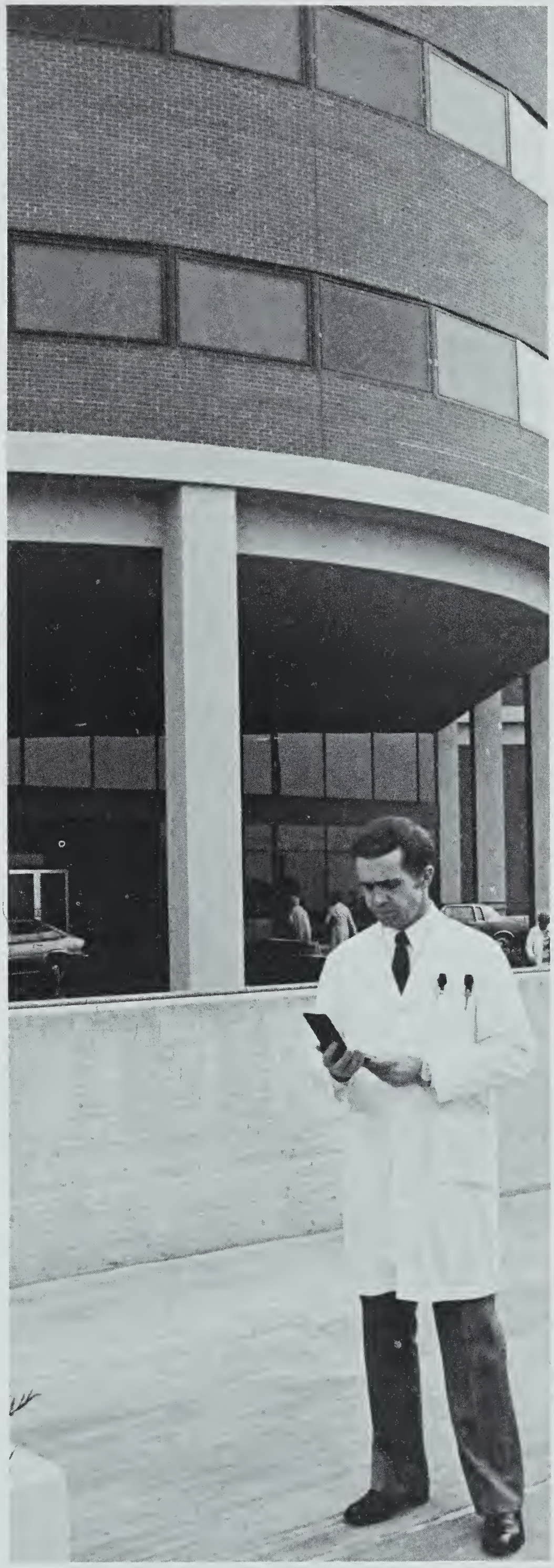
Dr. Newton saw him immediately, picked up the phone, made one phone call and Ron Henderson had a summer job at Continental Gin, on the 3 to 11 shift.

His role model, early and late, was Dr. Newton, who had begun to be an encouragement about the time Henderson began playing end on the Autauga County High School football team.

Winning his B.S. in 1958 and his M.D. in 1962, Dr. Henderson went on to be tapped Outstanding Intern in 1963.

In fulfillment of his state scholarship obligation, and because he still wanted to emulate Dr. Newton, he spent two years, 1963-65, in general practice in Gordo.

But he had been brainwashed, as he puts it, while in medical school and longed to return for specialty training in obstetrics and gynecology. He had been inspired while on this rotation by two residents who loved what they were doing and were intensely interested in patient care.



"You get brainwashed in the first two years," Dr. Henderson recalls, "and when you hit the clinics you are really set up to go into some specialty. I think it's still that way; it hasn't changed a bit. You are brainwashed into believing you can't practice in a rural setting, that you have got to have the mecca, all that sophisticated equipment and technology, to survive.

"I was prone to that. . . ."

He was also prone to hard work and dedication. The graduating class of 1968 named him Best Resident.

Farewell to Tuscaloosa

He had planned to return to Tuscaloosa to practice, having contracted that community's famed village virus, but received an irresistible offer from St. Vincent's Hospital in Birmingham. He has practiced there since 1968.

Early on, earning his niche in medicine, the attendant rewards in remuneration and recognition were important goals. Now he is elevating his sights to other life objectives according to plans crystallized during his hospital stay.

Although he is still fascinated by the romance of his work, he has set for himself new mountains to climb, thus to keep the creative juices flowing.

"If I fall off the ladder, if I can't reach another rung, I'll bail out.

"I realize I have a lot of growing to do. I have a lot of learning ahead of me. I will get into some fights and probably get bloodied. But I don't see many people without stature who have achieved the presidency of AMA. They are tough but compassionate, with a lot of ability. I may not have it, but I'm going to give it a shot.

"I feel that my diverse background — rural rearing, state university, exposure to rural health again as a general practitioner, and my specialty practice in an urban area — gives me an opportunity that other people don't have.

"I have had tremendous support around the state. Members of the Board of Censors have encouraged me. Dean Pittman [James A. Pittman, Jr., M.D., Executive Dean, UAB School of Medicine] has given me a lot of support."

Dean Pittman nominated Dr. Henderson for the MASA presidency at annual session in Mobile last year. While he was at it, he tacked on the nomination for the AMA presidency. That was out of order but definitely in harmony. The Dean says:

"Ron Henderson has been an outstanding person since he was in medical school. He has seen medicine from the 'real doctor' point of view in his general practice in Gordo. He is a highly respected specialist now in Birmingham.

"He has seen medicine from the consumer point of view in his traumatic automobile accident. He knows, as well as anyone I can think of, what medicine is and what it ought to be. I support him 100%. . . ."

Where It Began

In grammar school, something happened that may have been a factor in Dr. Henderson's parallel interests in farming and public service. He entered an essay in a county-wide contest on What It Means To Be An American. He won a Yorkshire gilt (a female pig) for his effort, convincing him that: (1) He always wanted to keep his hand in farming; and (2) he could achieve the heights if he wanted to.

The family farm had been mainly devoted to row-cropping, but Dr. Henderson thought the greater Romance (the operative word for him) lay in cattle farming.

In 1963-64 he bought a half-interest in the old home place from his Dad, cleared the land and began thinking cattle. He bought his present 1,600-acre spread in 1970 a few miles from the old home place.

Twin Valley Farms, as a sign prominently proclaims it, is presently home for about 500 head of commercial cattle and 60 registered cattle, Angus and Hereford, and bulls.

The population includes one that may be the wave of the future: an embryonic transplant. Dr. Henderson:

"I feel it is the quickest way to get a superior herd without costing an arm and a leg."

Transplant, now being done widely, enables the cattleman to leapfrog several generations in his breeding work. The embryo may be transplanted immediately to the donor cow or frozen for later use.

"They are doing cloning now," Dr. Henderson says, "getting three individuals exactly alike genetically. They take the embryo in the early stages, split it and then, because of time, split it again so that they end up with three individuals of the same genetics. Conception rate is about 17%, which is pretty good.

"Veterinary science is far ahead of human reproduction. But they don't have to worry about religion and morals and other hang-ups."

Theme for 1982-83

As MASA President he hopes to have an impact in an area dear to his heart since the earliest days of training but intensified and given shape by his automobile accident — patient advocacy.

"I want physicians of the state to realize and to remember that they are the patient's advocate. The Medical Association is a perfect place for such an attitude to be promoted. It's not only the way it *ought* to be: it's the way it's *got* to be.

"We've got to get away from the idea that the attending physician does not always perceive himself as the primary care physician — with the result that the patient really doesn't have an advocate.

"Also I want to educate the physicians of this state about what is happening in our society affecting medical care. Most physicians are not aware, I'm afraid, of

continued on page 17

Compared to amoxicillin

Faster peak. Fewer problems.

. . . in infants and children

Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).[1]

Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.[2]

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.[2]

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.
2. Multicenter trials. Data to be published.

See important information on page after next.

Compared to ampicillin

Faster peak. Fewer problems.

. . . in adults and children

Cyclapen®-W (cyclacillin) produces peak serum concentrations* almost four times higher and over one hour earlier.[3]

Cyclapen®-W is just as effective in otitis media, bronchitis, pneumonia, urinary tract infections and infections of skin and skin structures†.[3]

Cyclapen®-W produces a significantly lower incidence of diarrhea and skin rash.[3]

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.
†Due to susceptible organisms.
3. Data on file, Wyeth Laboratories.
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See important information on adjoining page

Wyeth Laboratories
Philadelphia, Pa. 19101

Cyclapen®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demanstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

Wyeth Laboratories
Philadelphia, Pa 19101

Dr. Henderson

continued from page 14

all the changes taking place — changes that, in the next five years, will alter the total landscape of medicine as we have known it in the past. So many pressures coming from so many sources make change inevitable. And it's right ahead of us. I want to be an instrument of educating physicians to these changes.''

Physicians are so busy these days, Dr. Henderson continued, they have not taken time to see what is happening to change medicine radically:

''For instance, industry's push to get a handle on costs. We have the highest quality of medical care the world has ever seen for any population. It's accessible to a higher percentage of patients than ever before.

''We've done so well, the cost is out of hand. If we don't get better control of costs, if we don't contain costs, I believe this failure is going to tear down the whole system.

''We have industry wanting change, unions saying that too much of their take-home dollar goes to fringe benefits; we have insurance companies saying they can't sell insurance because the cost is prohibitive.

''I think physicians should take the lead. They're the ones who *must* take the lead. I think that because of the entry into the health care system of the for-profit corporations, competition has gotten so intense among hospitals they don't have a long-term view.

''They spent $1.2 million on CON applications alone just in Jefferson County last year. That's passed on to the patient.

''Physicians have got to be willing to look at alternative methods of health care: outpatient surgery, outpatient diagnostic procedures, promotion of good health — exercise, no smoking, weight control, the whole bit.

''If we can achieve these things, we can salvage some part of the free practice of medicine. If we don't, it's going to change. You have the pressures to contain costs at the same time we are facing a doctor surplus. With those two factors in the equation, something is going to happen.

''Maybe when this competition begins to hurt, more doctors will be interested in salvaging the free practice of medicine.''

Keep Moving On

Dr. Henderson is a restless and impatient man at times, reflected in his compulsion to get up and walk around when meetings drag on.

That he is driven, he freely admits. And he has expressed some concern for the bellicose scowl that descends over his face at times, even when he may be thinking the most placid thoughts.

The root of that dark and malevolent visage could be the small, insistent voice inside that keeps admonishing him to stop all this shilly-shallying and get on with the life plan. ⊡

LETTERS TO THE EDITOR

Canonizing Dr. Bennett

Editor, The JOURNAL:

The November issue of the JOURNAL of the Medical Association of the State of Alabama lauding Dr. Claude Bennett demonstrated Alabama's rich inheritance of native talent. As one who has had an opportunity to interact with both the basic science and clinical aspects of Dr. Bennett's leadership, I velieve that the university is indeed fortunate to have him. They have made an excellent choice of Dr. Bennett as chairman of the Department of Medicine. The people that he has drawn together in immunology are the best amalgamation of clinical acumen, intelligence, and scientific objectivity one could ask for.

In spite of this, I must strenuously object to the canonization of Dr. Bennett. The statement that "he is an inspiring leader who has almost single-handedly lifted the medical school out of its bad national showing in the basic sciences and made it the leader" is a form of hyperbole ill-advised for those taking the hippocratic oath and possessing some modicum of accuracy.

Dr. Bennett himself was fortunate to find a basic science area in which other great men had prepared a milieu for him to work. With apologies to many, I would like to list but a few. In biochemistry, Dr. Ward Pittman's textbook is an internationally recognized reference. Dr. Sam Barker gave us a test used worldwide for thyroid function. The PBI for many years served as a standard of objectivity in what had previously been a subjective area. Dr. Robert Mallory's AB-PAS stain is utilized to help specifically classify lymphomas. It has helped greatly to add precision to chemotherapy. Dr. Tryphena Humphry was one of the world's foremost authorities in developmental neuroanatomy. This list is but a small sample of the internationally known individuals who prepared Dr. Bennett's way. It is nowhere complete, but I believe it adequately refutes the "bad national showing" statement.

I wish Dr. Bennett good fortune in his future endeavors. If he has a few more touts such as that written by W. H. McDonald, I believe that he will need them.

O. JAMES STAATS, D.M.D., M.D.
Birmingham

Bad Taste

Editor, The JOURNAL:

In my opinion two of the articles in the January 1982 issue of the JOURNAL are in bad taste. The article on DMSO and the article about Jim Folsom. The latter is a particularly blatant invasion of the subject's rights to privacy. It is hard to imagine he and his family giving permission to Dr. Morris to publish it.*

I usually enjoy reading your journal, but I think these two articles seriously detract from it's quality.

C. GLENN COBBS, M.D.
Professor of Medicine
Director, Division of Infectious Diseases
UAB

** Both Governor and Mrs. Folsom granted permission. These affidavits were published with the article. — Ed.*

75 Years Ago

WILLIAM L. SMITH, M.D.
Editor, *The Journal*

Seventy-five years ago there were 17 licensed physicians residing in Coosa County, Ala. Adjoining Elmore County had 18; Jefferson County, the most populous, had 381.

In contrast, today Coosa has one licensed physician; Elmore has 23; and Jefferson, 1,816, of which 1,268 are members of MASA, 548 are non-members (including 319 residents in training).

In 1907, one Coosa County physician was a botanist by training. There were County Boards of Medical Licensure up until that year. The Act creating the Board of Medical Examiners was enacted in 1907 and went into effect on the first of September 1907.

The 1907 annual meeting was held in Mobile, April 16-19. The social event was at the conclusion of the meeting. The members repaired to the dock at the foot of St. Michael St. and boarded a "capacious boat, by name, *Hard Cash,* which would take them for a delightful sail on the Bay."

The *Hard Cash* was under the supervision of one Ananias, with a surname of Modern. Ananias likened his charge to Noah's Ark and had on board a trained seal, a tame fox from Jefferson County, and sundry other animals.

The Board of Censors suspended the membership of a Clay County physician for one year for treating another member's patient before the aggrieved was formally dismissed from the case. (How times have changed.)

Dr. J. Max Austin was a delegate from Elmore County to the 1907 annual meeting. Today, J. Max Austin, Jr., M.D., of the same family, practices in Birmingham.

The Jerome Cochran Lecture was delivered by Nicholas Senn, M.D., of Chicago. Dr. Senn was born in Buchs Canton of St. Gall, Switzerland, Oct. 31, 1844, and died Jan. 2, 1908, in Chicago. The cause of death was given as "chronic interstitial myocarditis and acute dilation of the heart."

The resolution establishing membership by demit for members moving to another county was introduced and passed at the annual session.

The more one studies the activities of the MASA in the past, the more one realizes that fundamentals hardly change.

WILLIAM L. SMITH, M.D.

The AMA: The Medical House of Glass

Edward Pedrero, Jr., M.D., Assistant Editor, in the
Journal of the Florida Medical Association

The AMA. Throughout its history, the name has meant many things to many people: a status quo-oriented association of stiff-necked dogmatism, an American institution bringing commentary into the arena of medical affairs, a large medical organization that helps support other medical organizations, organized medicine's debating society, the federal medical sovereignty, and so forth.

To the writer, the American Medical Association is like a glass house, a paradox. Few organizations have operated so completely in the glare of publicity; it is virtually a goldfish bowl. Yet despite all its translucence, the AMA remains widely misunderstood. Such is the paradox.

Sailing as it was compelled to do, without charts to guide it or precedent voyages of discovery, the AMA was guided by its founding fathers between rocks and whirlpools — between the demand of state societies, specialty groups and individuals jealous of a sovereignty, and the health care needs of a country destined to become the greatest power in the world.

The AMA has grown prodigiously in power and in its influence upon the medical needs of America and the entire world. The AMA has become an institution with all the term implies regarding roots and a respect for tradition. It is, for the American physician, a continuing body linked both to the past and the future.

Presidents of the AMA are not Titans. They are mortal men, generally endowed with more than ordinary intellectual powers and with exceptional richness of learning and experience, but nevertheless, subject like other men to eccentricities and failures of understanding.

From time to time the AMA has cause to acknowledge errors and correct itself, overturning its own past judgment, not capriciously on the basis of changing personal preferences, but rationally in the light of logic and experience.

Rhetorical flourishes and emotional outbursts against the AMA are increasing. Many members and non members alike complain of the vagueness and vacillation of AMA policy toward relations with unscientific practitioners. Some speciality societies question the AMA retaining a veto right over graduate medical education; individual speciality societies want greater control over the residencies in their specialties. Women physicians are concerned with the AMA's failure to endorse the Equal Rights Amendment.

The AMA is a glass house that affords an outlet for dissent, individuality, idiosyncrasy and a divergence from accepted official or conventional wisdom. Even the AMA's most passionate critics have to concede the value of most of its activities. Although there have been issues where the AMA's intentions and pronouncements were somewhat doubted, the physician members of the AMA have inevitably been the master of their own destiny and shall continue to be. In baseball parlance, the AMA has piled up a lot more hits than strikeouts.

Seldom in the course of American medical professionalism has the spirit of brotherhood been more sorely needed than it is today. The problems that we doctors face are of such a nature that they tend to divide rather than to unite us. We must realize that unselfish devotion to a common cause will strengthen individual faith.

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We should remember that the conflict with socialized medicine in America today is between our form of free society, based on the primacy and moral worth of the individual, and the despotism of socialism in which the individual patient or physician is solely viewed as a small cog in a great inhuman machine.

The dynamism of a free society, despite its inherent faults and weaknesses, has a greater vitality and capacity to be adaptable than a rigid, monolithic American socialized medicine can ever hope to achieve.

We should not indulge in any premature rejoicing or loud hosannahs because a conservative now is President of the United States. This is no time to relax or to weaken our defenses, physical or moral; it is a time for unity, cooperation and collaboration, a time for interdependence of medical organizations. This is the time to strengthen, not to weaken, the AMA.

You do not frighten physicians into joining and supporting the AMA, any more than you frighten people into building a nationwide bomb-shelter system. You must convince physicians that the right, necessary and sensible thing to do is to join the AMA. Let us never forget that associations such as the League of Nations have failed because the members were not ready to live up to their obligations.

We must eliminate, or bridge, the chasm between the silent inactive majority and the dedicated active minority. Many physicians question the value of the network of associations into which the strands of organized medicine have been woven. Some would reexamine, reduce, or even eliminate this network.

This web of interdependence owes its strength to the AMA's long-range policies and the Medical House of Glass's ability to rise above the maelstrom of immediate events and crises.

Outside isolationism provides the mechanism for breaking the web of interdependence. Physicians cannot isolate themselves from the organizations representing them.

We practice in a complex professional, economic and social framework that responds to a variety of pressures. Alone we cannot exert much influence on that framework, but collective and cohesive strength can make a difference.

If the AMA is found wanting, it is due to lack of member support rather than intrinsic weakness.

EDWARD PEDERO JR., M.D.
Tampa

Medical Education in Alabama: Part I, The Early Years

James A. Pittman, Jr., M.D., Executive Dean, UAB School of Medicine

Colonial and Indian Medicine

The history of medical education in Alabama very nearly parallels the growth of scientific medicine in the western world, for it began only in the middle of the 19th century. With the exception of Mobile and its environs, the land we now know as the State of Alabama was simply Indian territory prior to the 19th century, and such medicine as was practiced here was practiced by Indian medicine men.[1]

However, the medicine practiced by the colonial physicians in the North was not much better and may have been worse for the patient, with the repeated blood lettings, purgings, and induction of severe and protracted vomiting to the point of exhaustion of a patient who might have previously been only mildly ill. The famous Cotton Mather (1663-1728) declared that human excreta (dung and urine) was a ''Remedy for Humane Bodies that is hardly to be paralleled'' and that urine ''had virtues far beyond all the waters of medicinal springs.''[2]* An Anglican missionary in 1709 described the death of a colleague as follows: ''This Gentleman had the misfortune to take Physick of a pretended Phisitian which work't so violently that it gave him 100 vomits and as many stools, brought the Convulsions on him, which soon carried him off, and caused him to purge till he was Interr'd.'' There was ''very uniform, bleeding, vomiting, blistering, purging, anodyne, etc., if the illness continued, there was repetendi, and finally murderandi.''[3] Such practices continued into the 19th century.

Thus, the medicine practiced by the Indians in the area to become Birmingham may have been better than that in Boston at the time. For the Indians' medicine was closely identified with religion, and the medicine man was also a religious and philosophical leader. Rational medicine was, however, arising in Europe. For example, the Europeans made use of their belief that smallpox was caused by some infectious agent rather than evil spirits in what may have been the first use of germ warfare. During Pontiac's rebellion in 1763-64, General Jeffrey Amherst spread smallpox among the highly susceptible Indians by arranging for them to capture infected blankets and handkerchiefs.[1]

That year, 1763, also saw the Treaty of Paris, which gave Mobile to Britain and established English supremacy in the area. In 1783 American control was recognized but was firm only in 1813 after the state was claimed (from Spain) as part of the Louisiana Purchase of 1803.[4] Washington County was established in 1800, but Alabama Territory was established only in 1817, three years after Jackson's defeat of the Creeks at Horseshoe Bend. Finally, the territory was established and recognized as a state in 1819, with a population of around 125,000, about half black, with some 500 free Negroes.

Frontier Medicine and Licensure

The shift of medicine from a spiritual to a rational basis, which was gaining momentum in Europe during the 17th and 18th centuries, was well underway during

* Some notion of the intellectual tenor of the times is the fact that both Cotton Mather and his father, Increase Mather, believed in witchcraft and the punishment of witches, though they opposed ''spectre evidence'' used at Salem in 1692. Increase Mather served as President of Harvard from 1685 to 1701.

most of the colonization of Alabama, which began in earnest only with the folk migration called "Alabama Fever," which broke out after the War of 1812 ended in 1815.[5]

Medical education during these early times was uncertain enough, and in the pioneer backwoods of Alabama it was either nonexistent or, later, largely unrestrained. Most of the reputable physicians probably immigrated into Alabama from elsewhere, like nearly all the rest of the adult European population of the early 1800's, but there appear to have also been self-proclaimed physicians, and it is reported that "in Alabama in the early nineteenth century charlatans and quacks far out-numbered qualified trained physicians."[6, 7] This led the reputable physicians in the state to agitate for the first medical practice act, which became law in 1823. It provided that:

1. No person shall be allowed to practice physic or surgery for a fee or reward unless he shall be licensed to do so.
2. All charges made to any person not licensed for services rendered as a physician or surgeon for cure of diseases shall be null and void.
3. There shall be five boards of physicians, to consist of three members each, to be elected by joint vote of both houses of the General Assembly; which boards shall meet annually for the purpose of examining all applicants for license to practice medicine.
4. These boards shall receive five dollars for every examination and five dollars for each license.
5. This money shall be applied to the purchase of a medical library for use of the board.[6, 8]

Thomsonian Medicine

However, some physicians, perhaps because of their political influence through numbers and wealth, were exempted from the licensure provisions. Such was the case with the Thomsonians (exempted in Alabama in 1832), who held that disease was caused by an imbalance between heat and cold in the body with cold gaining ascendancy. Cure was sought by achieving "a state of perfect health . . . from a . . . balance . . . of the four elements."[9, 10] The loss of natural heat was supposed to be caused by "obstructions," particularly of the stomach. Thomsonian therapists sought to correct this imbalance by administering a variety of plant substances, especially lobelia, to induce physiological responses, such as sweating and vomiting, followed by cold baths to induce shivering, a steam bath with application of hot bricks, enemas, more lobelia, cayenne pepper, bayberry, and other emetics.

In 1809 Samuel Thomson (no relation to Sir William Thomson, Lord Kelvin) was acquitted of a charge of having killed a patient with his treatments, and around that time he obtained a patent on his system. With the patent in his possession, he launched a vigorous advertising campaign, using printed advertisements, agents, testimonials, personal appearances, and the like, to entice laymen into paying $20 for the right to teach the Thomsonian system to patients and to practice it. These subscriber-students were organized into "Friendly Medical Botanic Societies," and Thompson's *New Guide to Health* went through thirteen editions and more than 100,000 copies between 1822 and 1839, in the course of which Thomson became a wealthy and influential man. In 1835 the Governor of Mississippi claimed half the people in his state practiced Thomsonianism.

There were Thomsonian medical schools and infirmaries all over the United States. Botanic journals were published. And national conventions of delegates from the Friendly Medical Botanic Societies were held annually.[9] This was the climate, then, in which medical schools began in the South, one in which physicians trained in major schools in Europe and to some extent northern U.S. contended with Thomsonians and other lesser medical sects. South Carolina established a "regular" medical school in 1824 at Charleston, Virginia in 1832 at the University of Virginia, Georgia in 1832 at Augusta, New Orleans in 1835, and Richmond in 1838. With financial assistance from state and local governments, these schools appear by modern estimates to have improved their standards steadily until the war began in 1861. However, these schools were unable to produce sufficient doctors to meet popular demands.

Alabama Medical Institute at Wetumpka — 1844

In 1844 the legislature of the State of Alabama granted a charter to the Alabama Medical Institute to establish a medical college at Wetumpka. However, before the regular physicians could act on this, a schism occurred in the Southern Botanico-Medical College at Macon, Georgia, and the dissenting faculty members moved to Wetumpka, where they joined the staff of the Alabama Medical Institute. The faculty of the Institute were themselves largely dissenters from the forerunner of the Macon school; i.e., Thomsonians. However, the Wetumpka school lasted only one session, closing in 1845, with the faculty moving to Memphis, Tennessee, to join the newly chartered Botanico-Medical College of Memphis.[9]

Stillborn Medical Schools

It is important to notice that official state charters were granted these botanico-medical schools in Georgia, Alabama, Tennessee, and elsewhere. The legislature of Georgia appropriated funds for the Thomsonian school. The Thomsonians' influence in Alabama was such as to enable them to pass in the 1854 legislature a law establishing a parallel licensing system with that of "the regulars;" i.e., physicians educated in the growing traditions of West European science and rational-

ism. Despite the hostility between the two groups, the irregulars continued in abundance. At the Selma meeting of the Medical Association of the State of Alabama in 1852, John P. Barnes reported on the number of practitioners in Mobile County:[11]

Regular practitioners	40
Homeopathists and Hydropathists	2
Root Doctors & Thompsonians*	3
General Quackery	3
Idio-electopathists	1

Dr. Barnes then voiced a plea to the Medical Association for concerted action against such practitioners,

TABLE 1
ALABAMA DATES BEFORE STATEHOOD

c. 10,000 years	**Indians inhabit Alabama: Cherokees in N.E., Chickasaws in N.W., Choctaws in S.W., Muskogees (''Upper Creeks'') in central Alabama, & Creeks.**
1519	**Spanish explore Mobile Bay**
1540	**Hernando de Soto explores Alabama from NW (Tennessee River)**
1540	**de Soto's battle with Tuscaloosa, bloodiest European-vs.-Indian battle in U.S. history**
1702	**French establish first lasting European settlements at Ft. Louis and Port Dauphine (on Dauphine Island)**
1719	**First Africans arrive in Alabama as slaves via Port Dauphine**
1763	**Treaty of Paris gives Mobile to Britain**
1783	**United States control recognized**
1800	**Washington County established**
1803	**Louisiana Purchase**
1805	**Chickasaws, Choctaws, and Cherokees cede their lands to United States government**
1813	**Spain concedes southern Alabama as part of Louisiana Purchase**
1814	**Jackson defeats Creek nation at Battle of Horseshoe Bend**
1815	**War of 1812 ends**
1817	**''Alabama Territory'' officially created by U.S.**
1819	**Statehood among the United States of America**

which was followed by strong advocacy by the Association for a state medical school. This finally culminated in the founding of the Mobile school in 1859.

However, other attempts occurred before 1859. As early as 1839 a charter was issued to the Medical Society of South Alabama (later the Alabama Medical Society at Selma) to found a medical school. The charter gave the school the right to grant diplomas, but it is not known if any were ever granted or if the school was ever established.[11] In 1849 another charter was issued to the president, trustees, and faculty of the Alabama Medical College in Montgomery. But again no formal school was ever established, and by 1873 so many trustees had died that no quorum could be assembled and the effort ceased.[6]

Graefenberg Medical Institute — 1852

Only in 1852, when the Graefenberg Medical Institute was chartered on Feburary 7, did Alabama obtain a medical education institution which continued over a period of years.

The Graefenberg Medical Institute was established by Philip Madison Shepard, a son of the frontier born in Columbia County, Georgia in 1812. His medical training began with an 18-month preceptorship with Dr. John B. Boone of that area in 1831-32. He then studied medicine for 4 months at the Georgia Medical College at Augusta, which awarded him the M.D. degree for his efforts and payments. However, he received a second degree in 1835, apparently from the same school, probably for repeating the same course of study. In 1836 Dr. Shepard moved to Lafayette, Alabama, where he practiced for the next 8 years and established ''a small medical school, which he designated, 'Students Institute.' '' Apparently this was a *pre*-medical school designed to prepare young men for admission to medical school.[9]

In 1845 Shepard moved to Wetumpka, where he engaged in anatomical dissections, medical debates, and some continuation of premedical educational efforts. Then, in 1846, he moved on to the newly established town of Dadeville in Tallapoosa County, where ''he bought land, built a house, started farming, and developed an extensive medical practice.''[9]

The details of the founding, operation, and finally the demise of the Graefenberg Medical Institute and other early Alabama medical schools have been thoroughly researched and described by Dr. Howard L. Holley, the founder of the serious study of medical history in Alabama, in his forthcoming book, *The History of Medicine in Alabama*.

In brief, Dr. Shepard ran an advertisement in *The Advertiser and State Gazette* of Montgomery in the summer of 1851. This announced the forthcoming opening of the ''Graefenberg Infirmary and Hydropathic Establishment,'' which was later chartered by the General Assembly as the ''Graefenberg Medical Institute of the State of Alabama.'' The charter stated that ''the graduates of this Institute were entitled to all the privileges accorded graduates of leading Medical Colleges.

The Institute was very much a family affair. Dr. Shepard installed himself as ''proprietor and professor''; his half-brother, W. Banks, was appointed

* Spelled with a ''p'' here.

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*Reference: 1981/82 *American Druggist Blue Book*

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INDICATIONS AND USAGE SU-TON contains pentylenetetrazol which may be helpful in the older patient as an analeptic agent when mental confusion and memory defects are present. SU-TON also contains vitamins, trace minerals, and iron, for those patients who may benefit by preventing the development of a deficiency

CONTRAINDICATIONS Epilepsy, convulsive disorders or known history of sensitivity to any of the listed active ingredients.

WARNINGS The safety of this preparation during pregnancy and lactation has not been established Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of SU-TON who have heart disease. While pentylenetetrazol does not act directly on the myocardium; the results from central vagal stimulation could cause bradycardia

ADVERSE REACTIONS Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

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OVERDOSAGE Signs and symptoms of acute overdose may be due principally from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage. Intensive care must be provided to maintain adequate circulation and respiratory exchange

DOSAGE AND ADMINISTRATION One tablespoonful (15 ml) 3 times a day 20–30 minutes before meals This drug is not for use in children under 12 years of age.

HOW SUPPLIED Bottles of 473 ml (16 fl. oz.) NDC 0524-1015-16

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president of the Board of Trustees; another half-brother, J. T. Banks, and a cousin of Mrs. Shepard, M. L. Fielder, were named trustees, along with two others. Over the nine years of its existence the Institute graduated about 50 physicians, including three sons of Dr. P. M. Shepard, John (graduated in 1855 at 18),

TABLE 2
MEDICAL DATES AND ALABAMA

1809	**Samuel Thomson acquitted of murder (by treatment) in Massachusetts; patents treatment**
1823	**First medical practice act in Alabama; no distinction between physicians trained in schools and those trained by preceptorship**
1824	**South Carolina establishes "regular" medical school at Charleston**
1832	**Virginia establishes medical school at Charlottesville (U. of Va.); Georgia establishes one at Augusta**
1835	**Governor of Mississippi says half population are Thomsonians**
1835	**New Orleans establishes medical school**
1838	**Richmond establishes a medical school**
1839	**Alabama legislature issues charter for medical school to "Medical Society of South Alabama" (later Alabama Medical Society at Selma), but school never opens**
1844	**Alabama legislature grants charter to start a medical school to Alabama Medical Institute at Wetumpka; school operates for one year (two courses), then closes**
1847	**First meeting of Medical Association of the State of Alabama**
1849	**Alabama issues a third charter to Alabama Medical College in Montgomery; never opens**
1852	**State medical association agitates for establishment of "regular" medical school to combat charlatans**
1852	**Graefenberg Medical Institute established by Dr. P. M. Shepard**
1856	**Charter for new state-supported medical school granted to Dr. Josiah Nott**
1859	**Mobile Medical College opens with Dr. Nott**

Phillip Madison, Jr. (graduated 1858), and Orlando Tyler (graduated at 17), and a daughter, Louisa. The three sons joined the faculty of the family business upon their graduation, but the daughter was precluded by the prevailing sentiments of the day from doing the same. She was, however, apparently the first woman to receive a regular course of medical instruction and an M.D. degree in the State of Alabama and perhaps the South.

The course offered by the Institute lasted either from May to October or from November to March. Tuition was $60.00, but lower rates were possible, especially during the summer months. The few students lived in an annex to the Shepard home and ate with the family. Bible study was stressed, and the students were encouraged to live a simple, religious, healthy life. He did most of the teaching himself until 1855, when his son John joined the faculty. There were anatomical dissections on cadavers obtained from executions, shipments from Mobile and New Orleans, and from grave robbing. A garden provided herbs for the pharmacy and the study of medical botany, and skeletons hanging from rods were available for study. There was a library and chemical and surgical apparatus, as well as the nearby Graefenberg Infirmary and Hydropathic Establishment for bedside teaching. Dr. Shepard also took students on house calls. Although there were no formal entrance requirements, graduation required that the student pass an examination administered by the Board of Trustees lasting "three days and three nights" and consisting of 5,000 questions. This examination was open to the public.

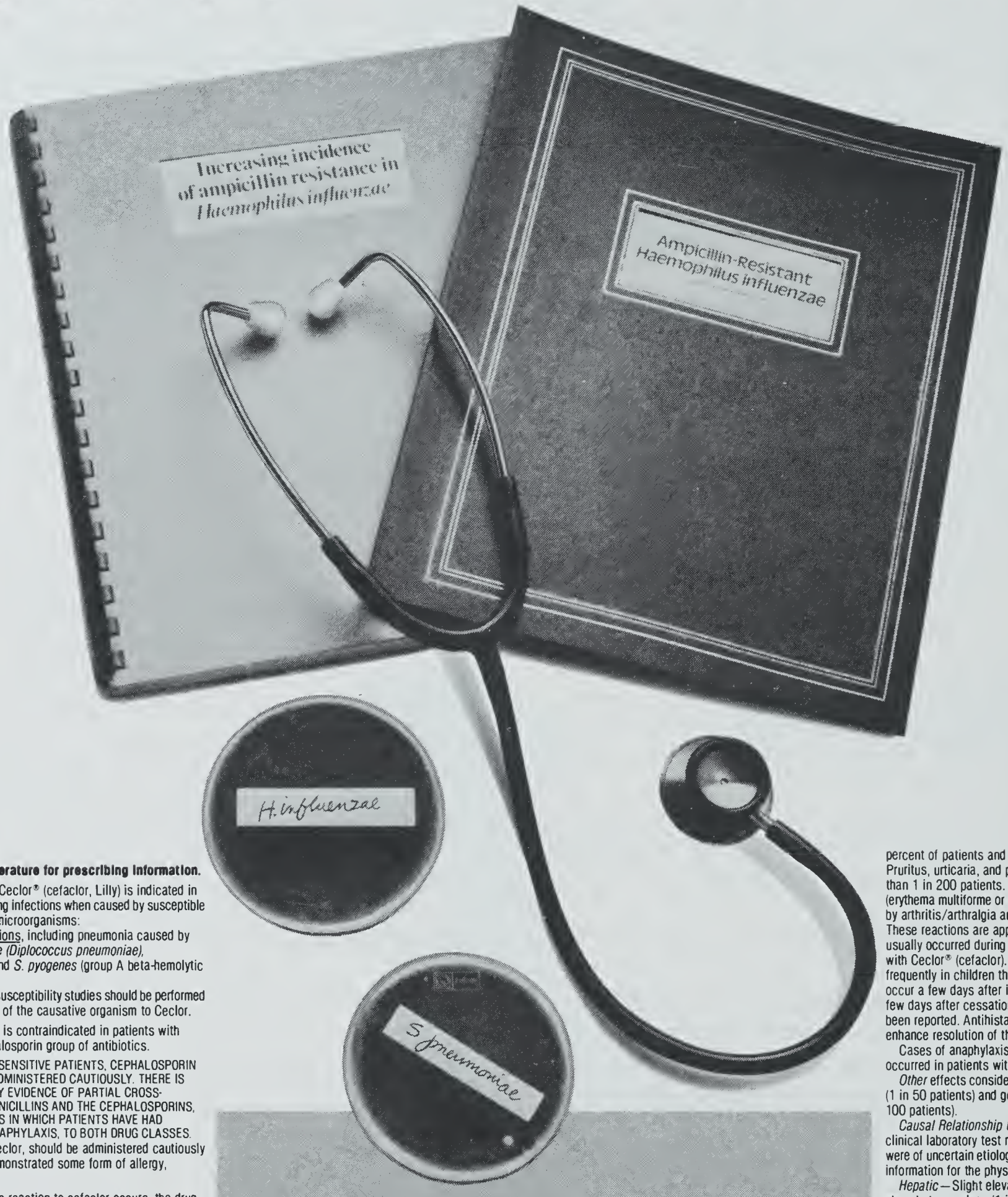
All in all, the Graefenberg Medical Institute seems to have provided a reasonable medical education for the time and place. However, when Dr. Shepard attempted to change its name to "Alabama Medical University" in 1860, he was rebuffed, since the medical profession and state government had turned their attention to the founding of a new state-supported school in Mobile. Shepard accidentally cut himself while performing an autopsy, contracted septicemia, and died; and the Civil War broke out, effectively ending the Graefenberg Medical Institute. The final chapter was written in 1873, when the main building burned, destroying the library, museum, and school records.

The Medical College of Alabama in Mobile

The first substantial and durable medical school in Alabama was The Medical College of Alabama, started in Mobile in 1859. The name of Josiah C. Nott, a surgeon, is the one most often associated with that school. However, there were actually three men who were crucial in the establishment of the school and its operation over the course of most of its existence: Nott, Dr. William H. Anderson, and Dr. George A. Ketchum. Dr. Holley's sketches[9] of the latter two follow:

"Dr. William Anderson's (1820-1887) credentials were impressive. A graduate of William and Mary College, he took a course of private lessons in medicine, and in 1842, after a year at the University of Virginia, received his M.D. degree. He practiced for a year and then became a resident at the Baltimore Almshouse Hospital. In 1844, he attended a lecture course in Philadelphia, and in 1845, he was in New York taking a year-long course of lectures at the University of the City of New York and visiting Bellevue Hospital daily with a private tutor. Dr. Anderson went to Europe in 1846 visiting London, Edinburgh, Berlin, and Paris. In Paris, he took an eight-month course with Claude Ber-

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note. Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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nard (1813-1878), the famed physiologist. In 1849, he settled in Mobile, practicing until his death in 1887.

"Dr. George A. Ketchum was a native of Mobile, read medicine with Dr. F. A. Ross, and served as resident medical student at the City Hospital for two years. In 1844-1845, he took a lecture course at the Medical College of South Carolina at Charleston and then interned at Old Blockley in Philadelphia. Later in 1845, he entered the University of Pennsylvania, took two lecture courses, wrote a thesis, and received an M.D. degree. After returning to Mobile, he was elected in 1848 physician-in-chief of the City Hospital. For several years he was in partnership with Anderson; and together with Nott and Anderson he founded a highly successful private infirmary for blacks. In 1847, Ketchum played a leading role in organizing the Medical Association of the State of Alabama."

However, it was Nott who was the chief advocate for a medical school in Mobile, and some of his ideas seem amazingly modern today. For example, he felt that there should be endowment funds to pay the teachers independent of the size of the classes. He said, "We shall never have any medical education in this country, as long as the pay depends entirely on the size of the class, and the schools are made matters of private speculation. The professors ought to be paid — ought to be compelled to devote more time to instruction, the course should be 7 months — should extend over 3 or 4 years — should commence with elementary branches, as Anatomy, Chemistry, etc., and there should be frequent examinations, as the classes advance, so as to keep boys always up to their work." He believed, "If the South had continued peaceful and prosperous, this scheme I think could have been worked out."[9]

The charter for the school had originally been awarded in 1856, but Nott was away teaching anatomy at the University of Louisiana. He returned to Mobile in 1859, obtained another charter from the probate Court of Mobile County, raised money (either $25,000 or $50,000 initially), and the school opened 14 November 1859. The sectional politics of the time and the growing possibility of armed conflict may have influenced the State Assembly to appropriate $50,000 to the school in 1860. The General Assembly had recognized the medical college as "the Medical Department of the University of Alabama" in 1859, but "The Medical College of Alabama," as it was called, was given a separate, self-perpetuating Board of Trustees, in addition to the State's contribution of $50,000 to purchase a lot and erect a building.[9] In return for this appropriation, the school was to accept, at no tuition, one indigent student from each county in the state.

In preparation for opening the school, Nott toured the major medical centers of Europe — London, Edinburgh, Munich, Vienna, Berlin, and Paris. He brought, or sent, back to Mobile a collection of equipment, specimens, and models said to be "equalled by no other institution in the United States,"[9] and some of these, the large paper mache models of human anatomy, are on display in the foyer of the basic science building of the University of South Alabama College of Medicine today, having been returned by me to that location upon their request in 1974.

Initially there were at least 9 paid faculty in the school, including Nott as Professor of Surgery, Anderson as dean and Professor of Physiology and Pathology, and Ketchum as Professor of the Principles and Practice of Medicine. There were 111 matriculants registered for the first session, who had satisfied the entrance requirements of at least one year of preparatory reading with a reputable physician. There were two sessions of 4 months each, and attendance at "two full courses of lectures in this institution" plus a thesis on a medical topic, written in English, Latin, French, or German were required for a degree. A course at another institution or "four years of reputable practice" could substitute for one of the two required sessions. Of the initial 111 matriculants, 15 won degrees as the first session ended in the spring of 1860.

At that time, in the spring of 1860, the new three-story building was nearly complete, with its two lecture halls, anatomy, chemistry, and pathology laboratories, its museum, library, examining rooms, offices, and associated structures. The future looked bright, and Dr. Nott and his colleagues looked forward to an enrollment of 200 to 300 students with an endowment large enough to pay the faculty to teach full time.

It was not to be. The school closed in 1861, when the entire faculty and student body joined the Confederate forces. Mobile fell to federal troops in April 1865, and the school's building was occupied and later converted into a school for blacks by the Freeman's Bureau. In 1868 the medical faculty regained possession of the structure and reopened the school, which, however, was so dilapidated that the task appeared hopeless. The faculty appealed to the state for money, but this was denied for two reasons: first, the state treasury was empty and the state was destitute; second, the reconstruction legislature had just repealed the law which gave the Medical College at Mobile its only state revenue. Dr. Nott, suffering from ill health, moved to Baltimore then to New York, never again to live in Mobile.

Nevertheless, Drs. Anderson and Ketchum, with several of the old faculty and some new, resumed operations in 1868 with 23 matriculants, 4 of whom graduated. Anderson remained dean until 1885, when he was succeeded by Ketchum. Dr. Ketchum served the school, first as Professor of Medicine then as dean, for a total of 47 years, serving in the latter capacity from 1885 to 1906. When he died in 1906, his estate bequeathed 1,000 books to the school's library.[9]

To be concluded, with all references after that conclusion. — Ed. ⊡

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Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.
Contraindications: Hypersensitivity to any component.
Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.
Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.
Adverse Reactions: Adverse reactions have been reported with specific vitamins and

ROCHE

5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]

minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

How Supplied: Golden yellow, capsule-shaped tablets—bottles of 100.

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highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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Back to the Gold Standard?

Eugene E. Stanaland, Ph.D.*

What Is A Gold Standard?

As you might have guessed, there is no simple answer since there are a number of versions of the gold standard. To begin with, lets look at the requirements for an economy to be on a Full Gold Standard:

- The standard monetary unit is stated as a fixed amount of gold;
- All currency and coin of the economy are freely exchangeable at their face value for gold and there are no restrictions on the use of gold by its owner;
- No limit exists on the amount of gold that may be brought to the mint for coinage;
- Gold is full legal tender for payment of all obligations;
- Gold is freely imported or exported to and from the economy.

If all the above requirements are met and the currency and coin of the economy are exchangeable into gold coin, which are multiples of the amount of gold constituting a monetary unit, then we would be on a Gold Coin Standard. If the currency and coin of the economy are redeemable only in gold bullion (large bars of, say, 400 ounces), the system is said to be on a Gold Bullion Standard. Obviously, the latter system would be a discouragement for the circulation of gold in the economy.

Modifications of the Gold Standard

A look at the history of the gold standard in the U.S. will reveal quite a few of the modified versions that are possible. Until 1933 we were on the Full Gold Standard as described above. In that year possession of gold by citizens was declared illegal except for dental, industrial, or jewelry uses. Gold was still used to meet international payments and was still "backing" our currency, but you could not redeem currency for gold. In 1968 gold reserve requirements were removed from our domestic money supply. Formerly, the Federal Reserve Banks were required to maintain 25¢ for every $1 of Federal Reserve Notes outstanding as well as for every $1 of reserves held by the Federal Reserve Bank for member banks to cover the demand deposits on their books.

In other words, the gold stock in the Treasury was no longer a limiting factor on the amount of money that could be created in the economy. The next modification came in 1971 when President Nixon abolished our commitment to exchange dollars for gold or any other foreign currency — meaning we went off the gold standard.

Why a Return to Gold?

Automatic Control of the Domestic Money Supply

Gold standard proponents say that two significant advantages will result from a return to gold: protection against undisciplined increases in the money supply and control over our deficit balance of payments with foreign economies. The first is the primary reason behind the present push for a return to gold. It is the belief of the pro-gold people that the solution to our

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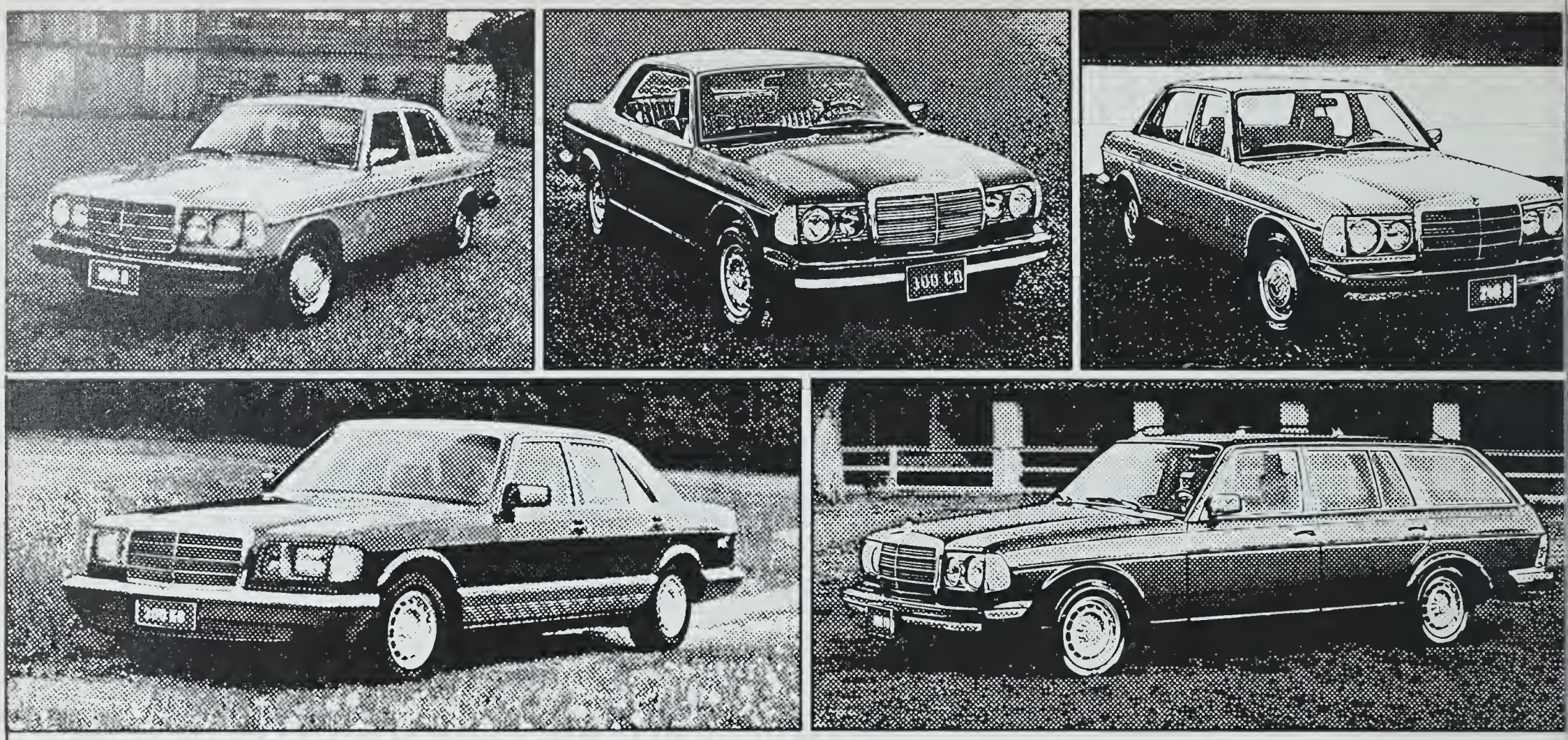

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inflation problem is a return of confidence in the value of our currency, especially in the long run.

It is believed that the present system under the Federal Reserve has not produced evidence that there is a willingness to control the amount of money being pumped into the system to avoid the excesses that bring inflation. The gold people say that tying the money supply to gold would bring about an automatic discipline that would insure controlled growth of the money supply and dispel concerns about inflation. This would cause interest rates in the money markets to fall immediately because lenders would not have to be concerned with charging a premium interest rate to offset the losses resulting from inflation.

With full redeemability of currency into gold, the people would cause the political and monetary authorities to exercise constraint in regard to inflation causing deficits and growth of the money supply through the banking system. This control by the public would be exercised by their ability to drain gold from the Treasury by exchanging their currency for gold at the first sign that Government was doing anything that would bring about a reduction in the value of currency through inflationary acts. If the people anticipated inflation they would realize that the currency would start to lose value as prices went up, encouraging them to exchange dollars for gold so as not to sustain a loss. On a Full Gold Standard the amount of money in the system would be determined by the amount of gold the Treasury held. A reduction in the gold stock would result in a reduction in the amount of money in the system and a reduction in economic activity, with a corresponding reduction in the price level — hence, solving the inflation problem.

This process is not unlike that of the tight money policy currently being pursued by our Federal Reserve Board. Holding the line on the money supply reduces the level of economic activity (recession) and reduces the inflation rate. Under the gold standard, drawing down gold balances would reduce the amount of currency outstanding and have the same result. A return of confidence in the currency and/or the economy would cause gold holders to return the gold to the Treasury in return for the currency, bringing about an increase in the money supply and an increase in the level of economic activity.

Control of International Balance of Payments

The function of the gold standard in balancing international payments results from the flow of gold in response to differences between imports and exports experienced by an economy. If we buy more from Japan than they buy from us, they might demand gold in payment for the difference. To the extent that gold flows out of this country, we experience a decline in money supply, a reduction in the level of activity and a declining price level.

This makes our goods more attractive to Japan. The gold that flows to Japan increases their money supply, leads to increases in activity, and an increase in price levels which makes their goods more expensive to us. The net result of these gold flows is to decrease our prices to them and increase their prices to us. These changes reduce our imports from and increase our exports to them, doing away with our deficit balance of payments to Japan.

Potential Problems

Domestic Stability

If the gold standard offers these many and needed services, why was it modified and eventually abandoned in this country? As in most cases, benefits do not come without costs. The automatic discipline of the public being able to trade their currency for gold would bring about a certain amount of volatility in the money markets. One might imagine the number of times a conversion of currency to gold might have occurred in our recent past, generated by uncertainty in the money markets.

However, the pro gold people maintain that the gold standard would eliminate the uncertainties so that, for the most part, people would prefer to hold currency rather than gold. One cannot help but speculate, however, about the effect of the recent best-selling authors who have made a handsome living forecasting doomsday in the economy. Just as inflation psychology can actually bring about inflation, one wonders if recurrent monetary crises might be more numerous if the supply of money were ultimately in the hands of average citizens who had the power to convert gold and currency at will and were subject to the advice of the ''expert'' and ''pseudo-expert'' out to make a bundle off of sensationalism.

Solve the Problem First?

It seems as though it would be necessary for us to solve our present economic problems before we could adopt the gold standard. The present deficit spending causes uncertainty and concern over the future value of the dollar. This is reflected in the high interest rates prevailing in the long term money market. A premium is being required to offset the expected inflation due to the uncontrolled Government deficits and increases in money supply through monetary policy.

If we imposed the gold standard in these circumstances would there not be a rush for gold of tremendous proportions? How long would it take the Congress and Federal Reserve to reverse the trends of the last 30 years to the point that the people would have sufficient confidence in the future value of the dollar, safe from the inroads of inflation, to convert from gold back to currency? How much gold would be necessary to satisfy the demand during a crisis?

Given the present U.S. stock of gold, it has been estimated that a $3,000 to $4,000 price per ounce

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Treatment failure was judged to have occurred when lesions increased in size and/or number during the initial week of treatment with penicillin V-K. *No* treatment failures occurred with Tegopen.

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Brief Summary of Prescribing Information

TEGOPEN®
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For complete information, consult Official Package Circular. (12) 9/11/75

INDICATIONS:

Although the principal indication for cloxacillin sodium is in the treatment of infections due to penicillinase-producing staphylococci, it may be used to initiate therapy in such patients in whom a staphylococcal infection is suspected. (See Important Note below.)

Bacteriologic studies to determine the causative organisms and their sensitivity to cloxacillin sodium should be performed.

IMPORTANT NOTE

When it is judged necessary that treatment be initiated before definitive culture and sensitivity results are known, the choice of cloxacillin sodium should take into consideration the fact that it has been shown to be effective only in the treatment of infections caused by pneumococci, Group A beta-hemolytic streptococci, and penicillin G-resistant and penicillin G-sensitive staphylococci. If the bacteriology report later indicates the infection is due to an organism other than a penicillin G-resistant staphylococcus sensitive to cloxacillin sodium, the physician is advised to continue therapy with a drug other than cloxacillin sodium or any other penicillinase-resistant semi-synthetic penicillin.

Recent studies have reported that the percentage of staphylococcal isolates resistant to penicillin G outside the hospital is increasing, approximating the high percentage of resistant staphylococcal isolates found in the hospital. For this reason, it is recommended that a penicillinase-resistant penicillin be used as initial therapy for any suspected staphylococcal infection until culture and sensitivity results are known.

Cloxacillin sodium is a compound that acts through a mechanism similar to that of methicillin against penicillin G-resistant staphylococci. Strains of staphylococci resistant to methicillin have existed in nature and it is known that the number of these strains reported has been increasing. Such strains of staphylococci have been capable of producing serious disease, in some instances resulting in fatality. Because of this, there is concern that widespread use of the penicillinase-resistant penicillins may result in the appearance of an increasing number of staphylococcal strains which are resistant to these penicillins.

Methicillin-resistant strains are almost always resistant to all other penicillinase-resistant penicillins (cross-resistance with cephalosporin derivatives also occurs frequently). Resistance to any penicillinase-resistant penicillin should be interpreted as evidence of clinical resistance to all, in spite of the fact that minor variations in *in vitro* sensitivity may be encountered when more than one penicillinase-resistant penicillin is tested against the same strain of staphylococcus.

CONTRAINDICATIONS:

A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

RESULTS OF ORAL THERAPY revealed a high percentage of treatment failures with penicillin V potassium, but *no* failures with Tegopen.

		Given Tegopen® *(cloxacillin sodium)*	Given *penicillin V-K*
Staphylococcus aureus	(78 patients)	39	39
Returned to clinic at one week		29†	38†
Treatment failure at one week		0	18 (47.4%)
Staphylococcus aureus* and *Streptococcus pyogenes	(9 patients)	4	5
Returned to clinic at one week		4	5
Treatment failure at one week		0	2 (40%)
No initial bacterial growth All 14 healed, regardless of which antibiotic was administered.	(14 patients)	9	5
Beta-hemolytic *Streptococcus*	(1 patient)	0	1
TOTALS:	**102 patients**	**52 patients**	**50 patients**

†Eleven patients did not return for their one-week checkup. These were all called by telephone, and their families reported the lesions had healed. One patient was dropped from the study, early, because of adverse reaction to medication.

STUDY: DESCRIPTION/PROTOCOL

- 102 nonselected subjects, with initial bacteriology as follows: 77% *Staphylococcus aureus,* 9% mixed *Staphylococcus aureus* and *Streptococcus pyogenes,* and 1% beta-hemolytic *Streptococcus*.‡
- All patients were given randomized therapy—Tegopen capsules or oral solution, or penicillin V-K tablets or oral solution, in recommended dosages according to body weight.
- All patients were evaluated after one week's therapy. If there was no improvement, therapy was switched to the other antibiotic. The "other antibiotic" proved to be Tegopen 100% of the time because no treatment failures had occurred with Tegopen.
- A final assessment of progress was made two weeks after initiation of Tegopen therapy.

‡The remainder, to equal 100%, consisted of 14 patients (13%) who exhibited no initial bacterial growth. These 14 were all healed, whether given Tegopen or penicillin V-K.

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WARNING:
Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents, e.g., pressor amines, antihistamines, and corticosteroids.

Safety for use in pregnancy has not been established.

PRECAUTIONS:
The possibility of the occurrence of superinfections with mycotic organisms or other pathogens should be kept in mind when using this compound, as with other antibiotics. If superinfection occurs during therapy, appropriate measures should be taken.

As with any potent drug, periodic assessment of organ system function, including renal, hepatic, and hematopoietic, should be made during long-term therapy.

ADVERSE REACTIONS:
Gastrointestinal disturbances, such as nausea, epigastric discomfort, flatulence, and loose stools, have been noted by some patients. Mildly elevated SGOT levels (less than 100 units) have been reported in a few patients for whom pretherapeutic determinations were not made. Skin rashes and allergic symptoms, including wheezing and sneezing, have occasionally been encountered. Eosinophilia, with or without overt allergic manifestations, has been noted in some patients during therapy.

USUAL DOSAGE:
Adults: 250 mg. q.6h.

Children: 50 mg./Kg./day in equally divided doses q.6h. Children weighing more than 20 Kg. should be given the adult dose. Administer on empty stomach for maximum absorption.

N.B.: INFECTIONS CAUSED BY GROUP A BETA-HEMOLYTIC STREPTOCOCCI SHOULD BE TREATED FOR AT LEAST 10 DAYS TO HELP PREVENT THE OCCURRENCE OF ACUTE RHEUMATIC FEVER OR ACUTE GLOMERULONEPHRITIS.

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Capsules—250 mg. in bottles of 100. 500 mg. in bottles of 100.
Oral Solution—125 mg./5 ml. in 100 ml. and 200 ml. bottles.

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would have to be set to cover the outstanding dollar claims held domestically and around the world. It is obvious that we could count on a fractional reserve system with gold just as we do with our present banking system. The assumption is that not everyone will demand conversion of their currency at one time. However, what price would be set for gold? It would appear that it could not be too far out of line with the world price. Too great a difference would cause inflows or outflows as world gold traders attempted to profit from the difference.

If too high a price was set relative to world prices, an influx of gold would take place that would add to our money supply and bring about inflationary tendencies. Too low a price would result in an outflow of gold reducing our money supply, bringing about a recession. Would a price that approximated world price be sufficient to cover the demands for gold during a period of domestic conversion to gold?

International Gold Flow Problems

In 1968 the gold reserve requirement was removed from the domestic money stock. The reason for this action was the fact that our consistent deficit balances of payments with the rest of the world caused a drain of our gold stock to other countries as they demanded at least partial payment of the deficits in gold. Our 1949 gold stock peak of $24 billion had dropped by the end of the 60s to $10 billion. In 1971 President Nixon discontinued conversion of gold for foreign currencies. We were forced to disassociate gold from the money stock because we did not have enough to cover the domestic money supply outstanding.

During the 60s our deficits never ran more than $5 billion. These deficits resulted in our having to go off the gold standard in the entirety to avoid losing all our gold. One wonders what would have happened in the 70s when we were running deficits in the range of $30 to $40 billion just for oil imports. How would we handle the problem of the large number of dollar claims now held by foreigners in terms of avoiding a complete drain of our gold stock? Short-term foreign claims are approaching $180 billion while our gold stock hovers near $10 billion.

Conclusion

One hesitates in this time of economic trouble to turn his back on what appears to be a viable quick fix for our problems as some of the pro-gold people maintain for a return to the gold standard. One continues to have the uneasy feeling that the return would be possible only after we have solved the problems the conversion to the gold standard was supposed to fix.

Are we prepared to impose the discipline of fiscal and monetary policy, not to mention foreign buying, military assistance, and foreign aid (that keep turning a favorable balance of trade into a negative balance of payments) to the point that foreign owners of dollar claims would not drain our reserves dry?

It seems there are a lot of questions yet to be answered before one could make up his mind about the practicality of a return to the gold standard. ⊡

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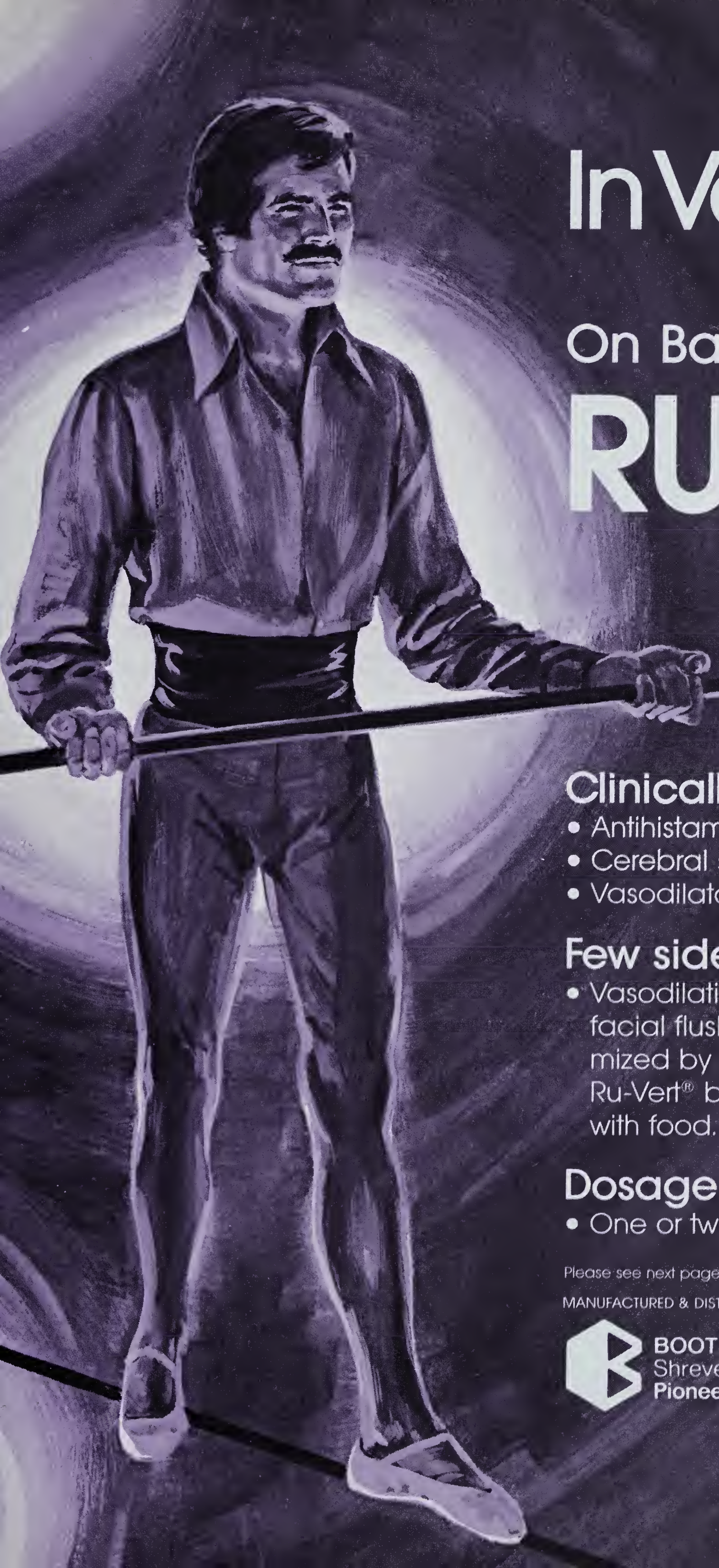

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Pentylenetetrazol	25.0 mg
Pheniramine maleate	12.5 mg
Nicotinic acid	50.0 mg

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- Antihistaminic
- Cerebral stimulant
- Vasodilator

Few side effects

- Vasodilation occasionally causes facial flushing which can be minimized by recommending that Ru-Vert® be taken following meals or with food.

Dosage

- One or two tablets three times a day

Please see next page for a summary of prescribing information

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See following prescribing information.

DESCRIPTION: Each tablet contains the following active ingredients:

Pentylenetetrazol	25.0 mg
Pheniramine maleate	12.5 mg
Nicotinic acid	50.0 mg

INDICATIONS: Ru-Vert is indicated as an adjunct therapy in the symptomatic treatment of acute or chronic vertigo.

CONTRAINDICATIONS: Convulsive disorders or known history of sensitivity to any of the listed active ingredients. Because of the vasodilating action of nicotinic acid, Ru-Vert should not be used in patients with hypotension.

WARNINGS: The safety of this preparation during pregnancy and lactation has not been established. Use of this drug requires that the physician evaluate the potential benefits of the drug against any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contraindications to pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold or a focal brain lesion. Caution should be exercised when treating patients with high doses of Ru-Vert who have heart disease. While pentylenetetrazol does not act directly on the myocardium, the results from central vagal stimulation could cause bradycardia.

Pheniramine maleate, like other antihistamines, may produce sedative side effects in certain patients.

Transient vasodilatation due to rapid absorption of nicotinic acid may produce facial flushing and a sensation of warmth. These effects may be ameliorated by recommending that Ru-Vert be taken following meals or with food.

ADVERSE REACTIONS: Pentylenetetrazol in high doses may produce toxic symptoms typical of central nervous system stimulants, which act on the higher motor centers and the spinal cord. Convulsions resulting from this drug are spontaneous and are not induced by external stimuli. They usually last for several minutes and are followed by profound depression and respiratory paralysis. Death has been reported from the ingestion of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reported with Ru-Vert.

OVERDOSAGE: Signs and symptoms of acute overdose may be due primarily from overstimulation of the central nervous system and from excessive vasodilatation with resulting autonomic nervous system imbalance. The symptoms may include the following: vomiting, agitation, tremors, hyperreflexia, sweating, confusion, hallucinations, headache, hyperpyrexia, tachycardia. Treatment consists of appropriate supportive measures. If signs and symptoms are not too severe and the patient is conscious, gastric evacuation may be accomplished by induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate circulation and respiratory exchange.

DOSAGE AND ADMINISTRATION: The recommended dosage of Ru-Vert for vertigo or motion sickness is 1 or 2 tablets three times a day with meals or light snacks.

This drug is not for use in children under 12 years of age.

HOW SUPPLIED:

Bottles of 100 tablets	**NDC** 0524-0060-01
Bottles of 300 tablets	**NDC** 0524-0060-03

Federal law prohibits dispensing without prescription.

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The Treatment of Chronic Eczemas of the Hands

PAUL G. REQUE, M.D., BIRMINGHAM

Summary Abstract

The following article is presented as an aid to the family practitioner in helping to decide upon a usually sufficient regimen for the common ''hand eczema,'' as well as suggestions to determine frequent etiologic agents. The physician-patient ''detective team'' approach is usually needed and may be quite rewarding.

The Management of Chronic Eczemas of the Hands

Eczematous dermatitis of the hands may be the most frustrating and yet one of the most frequent eruptions confronting the physician. The hands, both in men and women, are exposed to innumerable contacants every day, so often in fact, that most contacts with various chemicals, metals, and biologic organisms are completely ignored, or overlooked. Fortunately the hand is adapted to many of the possible irritants by a much thicker layer of keratin on the palms than on it's dorsal aspects, and since most contacts are with the palmar surfaces of the hand there is less liklihood of damage to the skin. One exception to the foregoing, however, is perspiration and moisture aggravated by the use of alkaline cleansers. It has been estimated that one-third of all eczemas involves the hand *(Rook: Textbook of Dermatology,* p. 214; vol. 1; Blackwell Scientific Publications, England 1969).

Not only is eczema of the hand often resistant to treatment, but recurrences are the rule unless the cause, or frequently causes, can be determined, and when possible, eliminated. It is therefore useful to assess the common causes of eczema of the hands in our attempt to prevent such relapses.

Correspondence: Paul G. Reque, M.D., 327 Professional Office Building, 840 Montclair Road, Birmingham, AL 35213.

Clinical Aspects: Contact irritants generally affect the sides and dorsal aspects of the fingers and hands, causing a dry erythematous scaling, or vesicular patches of dermatitis. When the palmar surfaces are involved one also considers endogenous causes and small vesicles and vesico-pustules which itch severely are seen on the thenar eminences and palmar aspects of the fingers often due to trapped excessive perspiration, aggravated by strong alkaline chemical irritants such as detergents. In the instance of ''ring finger'' dermatitis a band of eczema may surround the proximal end of the 4th finger.

Etiologic Agents

1. Allergic individuals with a history of atopic eczema are very likely to develop a patchy, coin-sized pruritic and erythematous eruption by the 3rd to 5th decades. This is often aggravated by the increasing responsibilities of the household or work-place, or stress of the style of life the patient encounters.

2. *Pompholyx,* a chronic vesico-pustular, eruption of the palms and fingers, often occurring without obvious cause in mid-life. It is extremely pruritic, and can be confused with psoriasis of the palms, as well as contact eczema.

3. *Nummular eczema* is a dry patchy eczema with spicules of dried serum which when scraped reveal a weeping surface. It is seen more often in cold weather, with dry skin, sometimes associated with a mild deficiency of vitamin A, and the use of drying anti-perspirants soaps.

4. *Exogenous dermatitis* of the hands, by far the most common and persistent of chronic eczemas, affects housewives and industrial workers alike. It usually has an obscure etiology, but with persistence, clearing is expected and the cause determined. Greases and solvents in industry are to be suspected.

5. *Hyperkeratotic eczema* of the palms where the palmar keratitin layer thickens remarkably usually as a result of cold, moisture, and local trauma, such as in fishermen who tend their traps and fish-lines daily.

6. *Asteatotic* (dry skin) eczema of the hands, is seen in elderly people with little moisture and thinned atrophic skin which has little resistance to even milder contactants.

7. *Miscellaneous* eczematoid eruptions — may be the scaling vesicular-pustular and erythematous lesions of the palmar and plantar psoriasis, often seen without any other psoriatic lesions on the body; congenital hyperkeratoses of the palms and soles; palmar infections with fungi or yeast organisms as causes, and less often the ''ID'' reactions consisting of a vesicular reaction of the skin due to the dissemination of toxins of a distant focus, either bacterial or mycotic, labeled ''bacterids'' or ''mycotids,'' ''tricophytids,'' ''monilids,'' depending upon the primary organism at the distant site. Their ''cure'' is obviously the clearing of the primary disease.

Treatment

It is in this phase of caring for eczema of the hands where considerable confusion and difficulty exists. It is probably an aid in this problem to categorize the various classes by age and sex.

1. Nearly all the chronic eczemas in children will be due to allergic, or atopic eczema. Skin testing for the allergens responsible for the eczemas is not often rewarding, especially the intra-dermal tests. However, if contactants are suspected the ''patch-test'' to suspected offending agent may be helpful. Rubber articles, i.e. shoes, grips on bikes, balls and other play-equipment should be considered. Frequently medicated and deodorant soaps are the cause. Elimination of such articles, should be considered. Frequently medicated and deodorant soaps are the cause. Elimination of such articles should be curative. While the eczema is present, avoiding soaps of all kinds, and using very mild shampoos can help alleviate the discomfort. One may use Westcort® 0.2% cream locally on the affected areas 3 to 4 times daily until clear. The strict avoidance of soaps, using ''Aveeno-Bar''®, Lowila® cake cleanser, or ''Emulave-Bar''® may relieve the tendency for even mild soaps to irritate during active eczema, and using soapless shampoos, such as ''Dara''® or ''D.H.S.''® shampoos may be helpful.

2. After the age of 15 years, contact-irritants and occupational contactants become more causative. Thus it also becomes helpful to separate male from female occupations in determining the possible causes of hand eczema.

A. Careful persistent inquiry about the work place,

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VA Study[1]

- 450 patients studied
- Mild to moderate hypertensives
- Comparison of propranolol and reserpine for Step-2 antihypertensive therapy
- **Conclusion:** when added to a thiazide diuretic, reserpine was effective in a larger percentage of patients (88%) than was propranolol (81%)!

HDFP Study[2]

- More than 10,000 patients studied
- Conducted at 14 centers over 5 years
- Proved that compliance with Step Care lowers death rate from all cardiovascular causes
- **Conclusion:** reserpine-thiazide regimens were *preferred* for Step-2 therapy, and were deemed effective, without significant adverse effects!

MRFIT Study[3]

- 6-year, 12,000-patient study, to be completed in 1982
- Assesses factors that may increase risk of cardiovascular disease
- Preferred Step-2 regimen: reserpine-thiazide
- **Full year's data:** reserpine is causing less depression than methyldopa, diuretics, or placebo!

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(hydroflumethiazide 50 mg/ reserpine 0.125 mg)

Is the preferred Step-2 regimen

Please see references and brief summary of prescribing information on adjacent page.

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For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy—Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS

Hydroflumethiazide—Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine—Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

The usual adult dose of Salutensin is one tablet once or twice daily. If a smaller amount of thiazide diuretic is desired, Salutensin-Demi, one tablet once or twice daily can be given.

SUPPLIED

Bottles of 10 and 1000 scored tablets.

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sports, hobbies and time of flare-up of the eczema is important. While grips on golf-clubs, tennis rackets, handle-bars, bar bells and other athletic paraphernalia are unusual causes of hand eczema they are sometimes discovered active irritants.

B. Perhaps more important in competitive sports is the generation of tension with it's ensuing perspiration, aggravation by adhesive wraps on the hands, tincture of benzoin and strong soaps and solvents used in final clean-up of the day.

C. When it comes to the work place, close investigation is sometimes invaluable. A good job description, contacts with chemicals in machinists, wire-drawers, pitch and pipe makers, diesel and other fuels, solvents such as mineral spirits and other petroleum products often used as cleansers for the hands are common causes of skin trouble. The list is endless, but there is ''double importance'' in occupational hand eczema in that it may be compensative, cause job-loss, and frequently disrupt relations with company management, labor-relations and federal regulations. A thorough investigation is usually rewarding, and it may uncover the fact that the employee has two jobs, ''moonlighting'' as it may be called, or have hobbies in which paints, varnishes, greases and oils and other chemicals may be used and causative. Nor are these contactants only in industrial context: office workers have occasional problems with inks, carbon-paper, ''Ozlid''® blue-print materials, duplicators, and daily cleansers provided by the employer.

D. About two-thirds of hand eczema the physician will encounter is seen in females, and of these the great majority will be housewives. The term ''housewives eczema'' has sometimes been used to describe this condition. It has been written that the average household contains ''52 chemicals in the kitchen'' which is not too many when one remembers detergents, furniture and silver polish, floor-waxes, baking sodas, various seasonings, bathroom disinfectants, window cleansers, insecticides, and soaps. It has also been estimated that the average housewife places her hands in water about 75 times daily, constantly rinsing foodstuffs and food-dusts and greases each day.

It is probably very likely that household detergents are far more potent and effective than in years gone by, but ''people'' have not become stronger nor has skin become tougher during this period and this should make for more problems for the homemaker. In place of rinsing her hands, it may be suggested that a clean towel be hanging in the kitchen and the hands ''dried-off'' rather than wetting each time, thus avoiding weakening the skin as much. Chefs in restaurant kitchens often use this method to avoid injury to their hands. Fortunately, automatic dishwashers are required in restaurants and hand washing is minimized.

In addition, housewives of today have much more responsibility *outside* the home, some being employed,

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Deadline for applications is 1 September 1982. All applicants are encouraged to also participate in the NIRMP. Selections for the Army FYGME Program will be announced in sufficient time for selectees to withdraw from the NIRMP.

To find out more information concerning this program, the eligibility criteria, service obligation, benefits, and application procedures contact:

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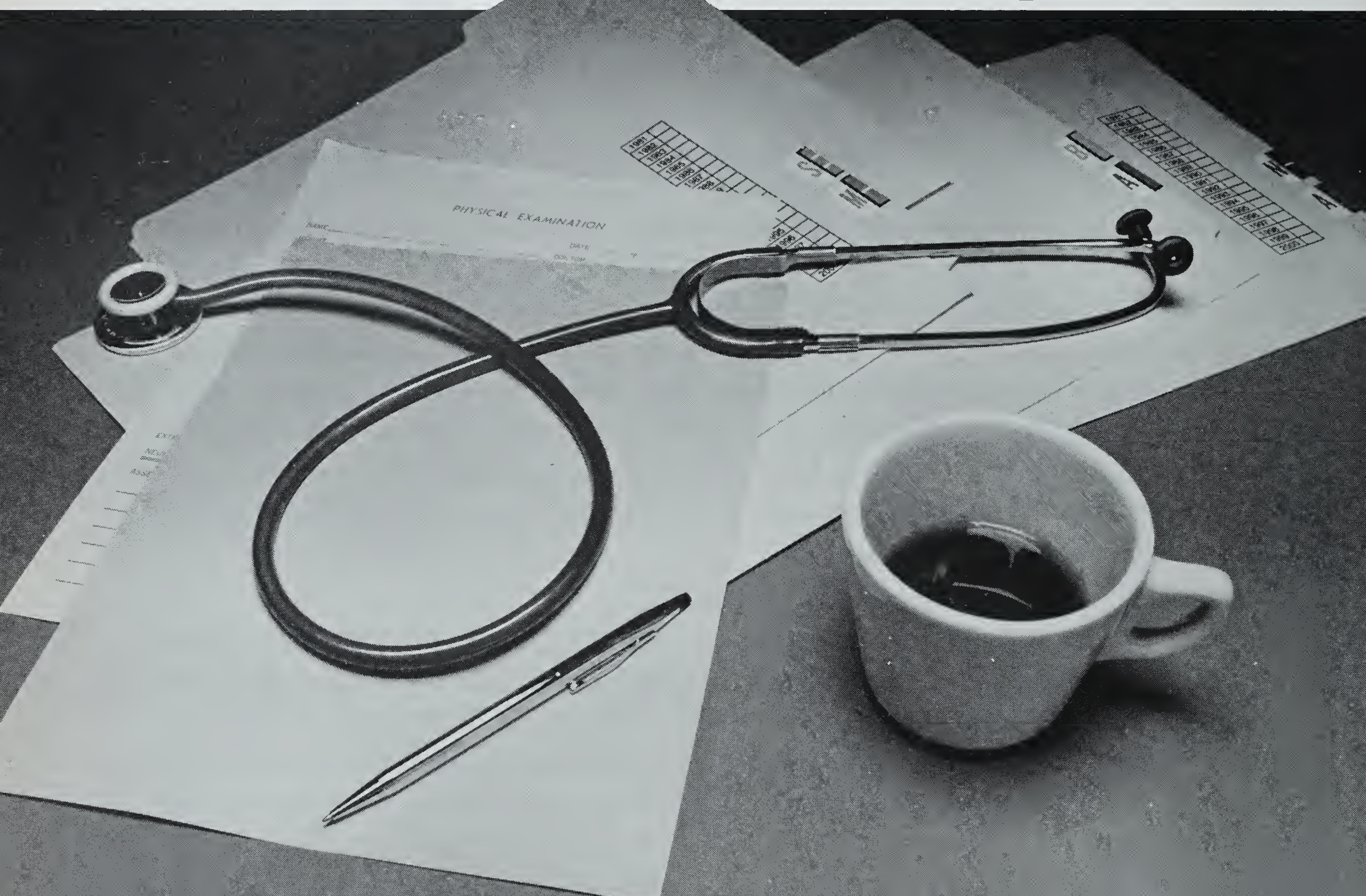

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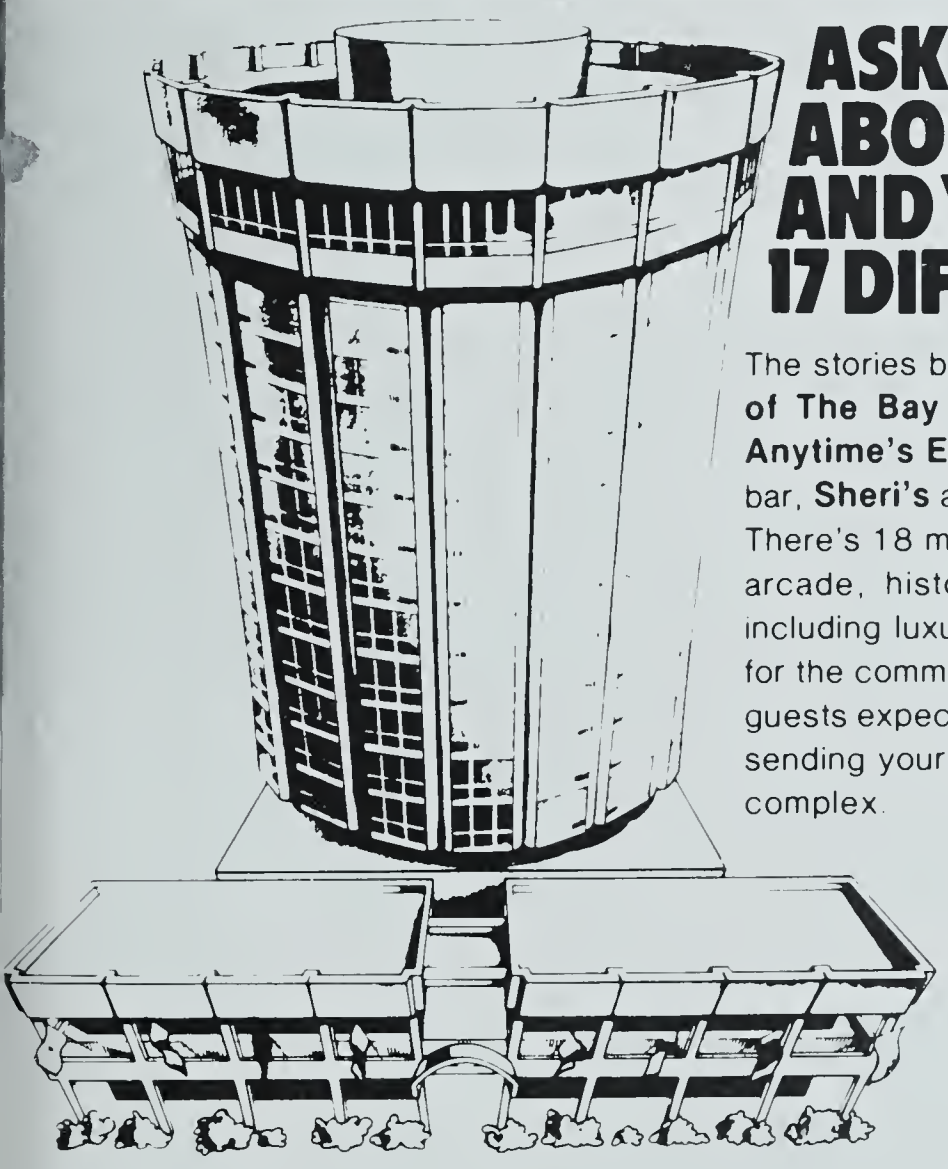
others carrying children to school, church, and doing other community projects, in addition to being the most socially-active member of the family. This creates considerable tension at times, conflicts occur, bosses are thoughtless, and competition always present, and this in turn leads to increased sweating of hands, increased itching and inevitably scratching, setting up the cycle of itching and scratching which is so hard to stop.

To begin therapy, avoidance of as many soaps, soap-powders, detergents as possible is recommended. A product named ''Safe-Suds'' (Ar-Ex Products Co.; Chicago, Ill.) is an excellent household cleanser for almost all household chores, and has very little tendency to irritate sensitive skin. For *personal* hand washing a cleanser named ''Phresh 3.5''® is very mild and usually better tolerated than the mildest of soaps, (Riker Labs.) ''Lindora''® (Westwood) can substitute nicely in the bath.

Begin active treatment by using mild Vioform® H. C. cream (Ciba Pharmaceuticals) twice daily, and wearing cotton gloves is occasionally helpful. Rubber-gloves cause profuse perspiration in warm water, and the cotton-lined ones are not much better in avoiding the sweating, so that light cotton gloves should be used beneath them. Once the eczema has subsided resorting to prevention and using ''Carmol-20''® cream after each washing and drying may keep further eczema from becoming a problem.

In severe and recalcitrant cases, it may be necessary to add a steroid systemically, and triamcinolone acetonide tablets, 4 mg to 8mg *after* meals may be added for a short time, perhaps a two weeks period. If not well tolerated by mouth, ''Kenalog-IM''® (Squibb & Co.) can be given in the gluteal muscle in amounts of 60 mg. It is not well tolerated when given in the deltoid muscle. The effect of the repository steroid should last about three weeks or more, and only one injection should suffice. In addition, ''Atarax''® tablets 10 mg, 3-4 times daily helps control itching and offers relief from tension in many instances.

By-and-large the real problem in chronic eczematous dermatitis are continuing preventive measures. The patient's cooperation is essential. Give the patient the decision of deciding on which chemicals and cleansers and other contactants add to their problems, and have them discuss alternative methods and products with the physician so that continuing prevention is used. Some so-called ''barrier creams,'' such as ''Skin Care Cream'' (Whorton Pharm. Co.; Fairfield, Al.), ''Kerodex Cream'' (Ayerst Pharm. Co.) and ''Special Skin Cleanser'' (Del-Ray Labs, Birmingham, Al.) may offer some help when the eczema has cleared, but should not be used as a substitute for carefull detection of irritants, and avoiding them. ⊡



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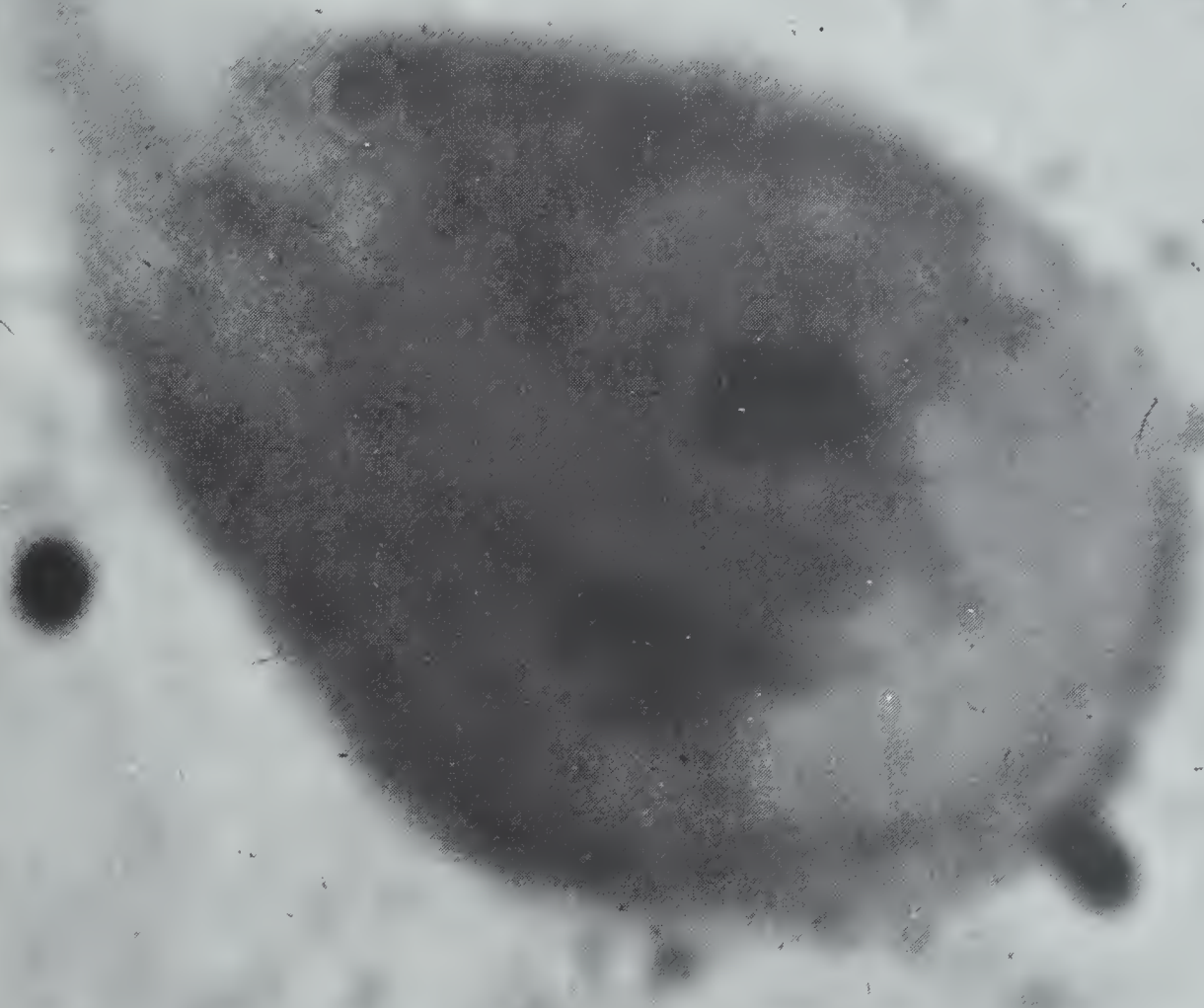

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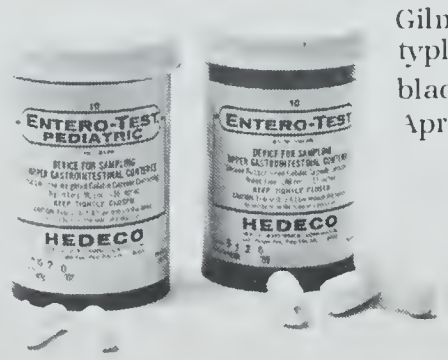

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AUXILIARY

1981-1982

Mrs. Rufus E. Lee, Jr.
President, A-MASA

A-MASA is an arm to the Medical Association of the State of Alabama made up of approximately 2,000 members. We have had an increase in membership for 16 consecutive years. No other Auxiliary across the nation can come close to this record. It is our duty to:

—Assist the Medical Association of the State of Alabama.

—Advance the cause of preventive medicine.

—Secure adequate medical legislation.

—To promote good fellowship among physician's families.

—To administer any endowment fund.

—To accomplish supplemental work as may be suggested by the Medical Association.

As you will recall last year, the AMA Auxiliary announced that for the third year we will continue to ''Shape Up For Life'' — the first year being *Through Better Nutrition* — the second year *Through Physical Fitness* — and this year *Through Mental Health.*

At the 1981-82 convention in Mobile, I announced my slogan for the year would be ''Serving Mankind Through Auxiliary.'' It gives me a great deal of pride and joy to say we, the Auxiliary to the Medical Association of the State of Alabama, have taken these goals and truly made them a part of our lives.

In cooperation with the Medical Society we held a Professional Communications Seminar given by Burroughs Wellcome Company teaching our members to interview doctors for public service spots on the radio. We felt this to be a good public relations project.

A top priority has been assisting the Medical Association of the State of Alabama in revitalizing the Impaired Physician Rehabilitation Program. This has been done by educating ourselves and other members on the subject. Last April, Dr. Charles Herlihy, Chairman of The Impaired Physician Committee for MASA gave us an insight on exactly what the plans would be for the year. As Auxiliary President, I was invited to become a member of this committee and on June 20, along with approximately 30 doctors from Alabama, who will act as intervenors, attended a workshop in Montgomery. Dr. Douglas Talbott and his team of experienced intervenors from Georgia taught us through lectures, discussions, and role play how to best approach a fellow physician and/or his family to seek and receive suitable treatment for drug and alcohol abuse. Every Auxiliary in the state has received information on this program.

On June 6 through 10, 11 delegates from Alabama attended the AMA Auxiliary Convention. George F. Will, *Washington Post* columnist and contributing editor for *Newsweek,* spoke to us on ''Medicine for and in the Economy.'' Dr. & Mrs. Gordon Deckert did a workshop on ''History of a Medical Marriage.'' We attended the installation of officers and we were proud to again be represented at the National level with Mrs. George Scofield being installed on the Board of Directors.

Our Fall workshop held in Montgomery on September 22-23, included Mr. Glen Bannister who spoke to us on ''Stress'' and Mrs. Margaret Clements from Georgia who gave a very informative workshop on ''The Impaired Physician.''

October 11 through 13, County President Elects: Mrs. Merrill Compton, Mrs. Julius Dunn, Jr., Mrs. E. Jackson Green, & Mrs. Robert Gillman; State President Elect Mrs. Robert Estock; and President Mrs. Rufus Lee attended Leadership Confluence in Chicago.

Winter board meeting was held in Tuscaloosa on Jan. 27. At this meeting, we had as our speaker, Dr. Robert Pieroni, who spoke to us on ''The Medical Implications of Stress Related Diseases.''

Auxilians across the state have held Worry and Stress Clinics. We have had programs on ''Handling Stress in Medical Marriages,'' ''Child Abuse,'' and other mental health programs.

We have donated (amount to be announced) to AMA-ERF from such projects as antique shows, basketball games, auctions, fashion shows, tasting teas, cookbook sales, giant rummage sales, Christmas card sales, and sharing cards. It is a pleasure to work on

continued on page 52

President's Page

continued from page 7

organized medicine in these United States. They do the same thing from the legislative point of view in the Congress of the United States that we from MASA do in the legislature of the state of Alabama.

In addition, it's the AMA that makes the presentations for you before Congress, congressional committees, regulatory agencies, bureaucratic organizations, and other divisions of the government. When you've got a gripe about a national problem, it's the AMA that funnels those complaints into its central office, amalgamates them and presents your views. When your state organization has a problem with a governmental agency, it's the AMA that is standing there to lend a hand, give you advice, and quite possibly support in resolving your problem.

In short, the AMA stands there ready to represent you before anybody, anywhere, anytime if they threaten the freedom of medicine to deliver the best health care in the world.

At both the state and national levels, your associations have the responsibility for evaluating and accrediting medical education at all levels. At the state level, MASA sponsors enough programs each year to keep you continually up to date on your CME hours.

Organized medicine sponsors practice management programs to help you begin your practice, make your practice more efficient, change your practice, and even plans for your retirement. While you are in practice they offer you insurance programs to help you keep your practice going and insure your life and health as well as help you invest your retirement monies in an equitable and remunerative manner.

In short, from the day you enter medical school and even before your acceptance into medical school, organized medicine holds out an umbrella over each and every physician in these United States. That umbrella ensures the quality of your education, the standards by which you are judged, and the training programs in which you participate. That umbrella then continues during your years of practice to ensure your ability to practice where, for whom, and under what circumstances you so desire. The broad wings of that umbrella extend outward to see that you are represented before, and protected from, the depredations of those who would alter your freedom and independence.

That is what organized medicine has done for you lately, is doing for you, and will continue doing for you.

With regard to what is in it for you — what's in it for you is the privilege of practicing medicine with the freedom and independence unknown in most of this world, to a quality surely unknown in this world, to a quality surely unequal anywhere in this world, and as free of restrictions as is humanly possible in these United States.

Membership in organized medicine is your best bargain — You can't afford not to belong!!

J. Kendall Black, Jr., M.D.
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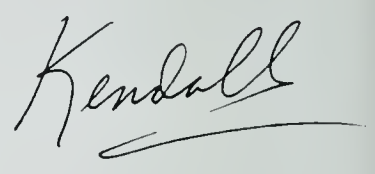

Auxiliary

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projects when you know the money is so badly needed and appreciated.

The auxiliary helped promote and co-sponsored a Health Education Workshop for teachers of Alabama schools at the University of Alabama in Birmingham in June of 1981.

A new project for the Auxiliary and the Medical Association this year has been the Medical-Student-Resident-Physician Spouse Program. All Auxiliaries were asked to have a program in February especially designed to reach out to our younger members. Mrs. George Scofield is national chairman of this committee.

Alabama members who attended Southern Medical Convention in New Orleans to see Mrs. William Hughes, past president of A-MASA, installed as President-elect of Southern Medical Auxiliary were — Mrs. Robert Estock, Mrs. George Scofield, Mrs. Ben Johnson, Jr., Mrs. Aubrey Terry, Mrs. Eugene Bradley, Mrs. William Smith, Mrs. James Ward, and Mrs. Rufus Lee.

It has been a great year for A-MASA with each member sharing the same values and working toward the same goals. I thank you for believing with me that these Auxiliary goals are important in achieving better health in Alabama.

As this year draws to an end, we are already setting our wheels in motion and our goals higher. We will endeavor to hold on to our values and make 1982-83 a year of greater achievement and advancement for a better quality of life in Alabama through A-MASA Volunteers.

Our sincere gratitude to the Medical Association of the State of Alabama, especially to Dr. Kendall Black, President MASA, who has been quick to answer our pleas for help. Also, to Dr. Ronald Henderson, Dr. Leon Hamrick, Dr. Rufus Lee, and Dr. Robert Estock for serving on our advisory council and to Mr. Lon Conner and his staff for their continued support in all our projects.

Our goal was to make getting there as much fun as being there.

Mary Julia Lee

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For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
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For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
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Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
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Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
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Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
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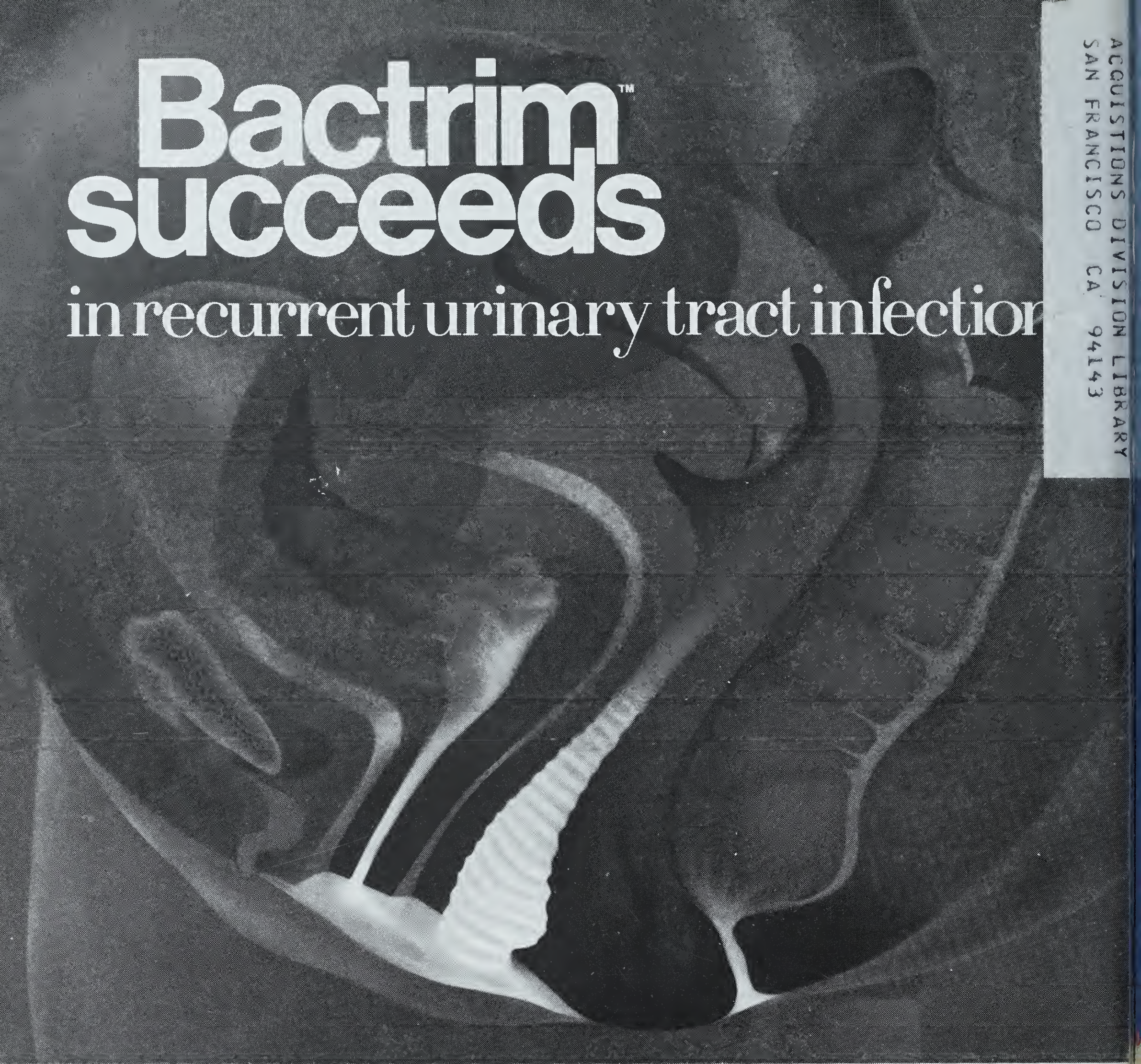

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1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980..**2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

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VOL. 51, NO. 11, MAY, 1982

SAILING IS FOR THE SOUL

By Claude L. Brown, M.D.

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THE PATIENT THINKS HE HAS HEART TROUBLE...

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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Partners in Health

This Month's Cover

The posterized rendering of eight-meter sailboats, created for MASA by George Pudzis of Graphics Factory, Montgomery, lends an element of unreality befitting the real-life nightmare of Mobile Psychiatrist Claude L. Brown, M.D. Although Dr. Brown won't admit it, there may be all kinds of allegories, analogues and symbolisms in his gripping account of an event that happened to him 25 years ago. Story, page 8.

EXECUTIVE DIRECTOR

S. Lon Conner
Executive Director, MASA

Trying Times

Long before the present imbroglio in Washington over the federal deficit and what to do about it, a few realistic economists and political leaders were warning that the resources of the United States were not infinite, as seemed to be a fondly held tenet of the Keynesians, but were finite.

No matter how compelling a social need might be perceived to be, nor how essential to the sociological model for the ideal state, the embattled few were saying, there just wasn't enough money in the country to pay for everything pronounced to be a need or an entitlement.

These pragmatic critics were generally rewarded with bitter denunciation by politicians of liberal persuasion, who were in the catbird seat. They were called naysayers. They were prophets without honor in their own land.

Now, all of a sudden, the acceptance of the finite nature of national resources has become the conventional wisdom in Washington. Not even Defense is secure from the roving bands of budget cutters. While most of us would like to have all the protection that money can buy from the threat of nuclear extinction, there is sudden realization in the land that there are limits even to how safe we can afford to be.

In this new spirit of embracing the truism that there are programs and policies the nation simply cannot afford, AMA President Daniel T. Cloud, M.D., told the subcommittee of the House Ways & Means Committee that "there is need for an evaluation of long-term health policies that will provide the proper care for our citizens within the available national resources."

Departing from a custom of many years standing, the AMA declined to offer specific solutions to 1982 Medicare problems, because this piecemeal approach has not given, and cannot give, the kind of leadershi necessary "to chart a course for the delivery of healt care in this country for this and future decades," Dr Cloud said. He called for fundamental new approache to all health programs — in effect, zero-based healt care budgeting.

He came close to using a word that I will use for hin — triaging. Not triaging in the battlefield sense or tha of the emergency room, but triaging in a basic econom ic context, using what resources we have to do the mos good, recognizing that the federal government canno nurture everyone back to health, save every life o mend every body, any more than it can afford to pro vide 100% assurance of national survival.

What is needed, plainly, is a rededication to some rather fundamental American ideals, which might wel begin with telling the families of the elderly, for in stance, that the routine warehousing of their unwantec in nursing homes is not a public responsibility, first anc last, but a private one.

In short, there must be a national return to individua and family responsibility, a deprogramming of the no tion that the country owes everyone total protection.

Some twenty years ago, a young American President exhorted the country: "Ask not what your country can do for you but what you can do for your country." Unfortunately, not many people took him seriously. At the time, to be fair about it, it did appear that we had discovered the answer to eternal prosperity and boundless economic expansion. Only a prophetic few seriously believed then that there would come a time like 1982 when Congress must decide how safe the nation can afford to be, or how free from fear and want. This, then, is the Day of Reckoning.

continued on page 53

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NEOSPORIN® Ointment
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- Handy applicator tip

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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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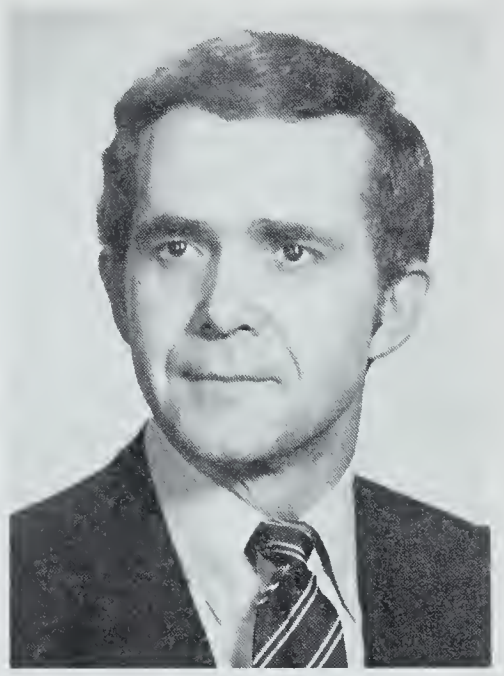
PRESIDENT'S PAGE

Between the Rock and a Hard Place



Ronald E. Henderson
President, MASA

There are three kinds of people: those who make things happen, those who watch things happen, and those who wonder what did happen.

As I sit down to write my first President's Page, my excitement is tempered by humility. Of all the opportunities and responsibilities that attend the office of President, none should be more stimulating than access to this page.

But it is a duty as well as an opportunity. The deadlines will be regular and unyielding. I hope that you will share my interest and concern in the topics I select. The President's Page will be as interesting and thought-provoking as I can make it.

Many problems confront American medicine in the 1980s. Some of these problems are direct results of our unprecedented successes. This year, we are delivering the highest quality of medical care to the largest percentage of a patient population in the history of mankind. This has been done, however, at tremendous sacrifice: the cost of medical care has become prohibitive to many segments of the society — the business community, government, the average citizen.

The share of personal health expenditures for the average family in 1980 was $2,850. If the current trends continue, it could be $4,900 by 1985, and more than $8,000 by 1990. In 1980 the nation's medical bill rose at the highest rate in 15 years while the gross national product declined. Health care expenditures consumed 9.4% of the gross national product, or nearly 10¢ out of every dollar produced in goods and services.

Regrettably, these are not temporary phenomena. They are the result of longterm forces which continue, with cumulative effect, to add to the country's skyrocketing bill for health care.

The successes which have brought this about include:

- Scientific progress which has made medical care increasingly effective and also more expensive, resulting in a rapid increase in the number and severity of diseases that we are able to treat, and a surge in the development of expensive health care equipment and facilities;
- The aging of the population;
- A change in the kind of diseases which most often afflict us, resulting from the elimination of a wide range of acute infectious diseases, and the increasing importance of longterm diseases, such as heart disease, cancer, stroke, which are more expensive to treat; and
- The effect of health care insurance arrangements, how health care is provided and how it is used by patients.

If medicine's successes continue as we expect them to, the first three situations mentioned above will only be compounded. But we can and must have an impact on how medical care is provided to and used by the patient. **Physicians are already erroneously being**

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Sailing Is for the Soul

Claude L. Brown, M.D.

Ask a psychiatrist to reveal the most painful episode in HIS life, and you are likely to get an evasive reply. But not from Mobile Psychiatrist Claude L. Brown, Jr., M.D., a frequent contributor to the Journal. *His nightmare, when he lost forever the love of his life, happened on February 16, 1957. It is now 25 years after that trauma and Dr. Brown says the pain is still there. The following account first appeared 22 years ago in an old boating magazine, long since defunct, which paid him a sum that wouldn't buy cab fare today from his office to Mobile Infirmary, a half-block away. — Ed.*

There was something about *Liv* that whispered an insistent song to almost everyone who stopped to look at her, and many did. This is the intensely personal song of any sailing ship, be she a pram or a fourmaster: the communication of a pervasive vitality, more lasting than the sunshine of the moment or the threat of the storm. A vitality, conveyed in the lift and thrust of her motion underway, or the promise of this as she lay in repose.

To call *Liv* a character boat would be comparable to calling Robert E. Lee a fine horseman; the terms, while not incorrect, somehow reduce the stature of the object by giving it an insufficient description. She *was* character. So my friend, Howard, looked at her as David must have looked at Bathsheba on the roof tops, and said simply, "We must have her."

No Triumph

This is no chronicle of triumphant seamanship; here is no story of a valiant wrestle with the forces of wind and wave, with man successfully matching his puny strength against the powerful but blind elements. Here rather, is the story of an effort at capturing the essentially unattainable. We tried to hold a vision too close, and came to grief!

Liv was an 8-meter, built in Norway and sailed there for some years. She had been shipped here on a freighter and belonged to a gentleman in New Orleans. Hers was the tallest mast in the harbor of the Southern Yacht Club. She was 43 ft overall, weighed approximately 12 tons and drew 4 ft 10 in. She had no motor. By all odds, looked at from almost any angle, she was a most impractical boat for us.

Take the matter of her draft; we sail in quite shallow tidal waters, and would very likely have been stuck in the mud on every sail. And I imagine that getting her hard aground in the tenacious mud of Mobile Bay would have necessitated removal by some means other than those in our possession. A tug, say.

Or consider the major difficulties involved in sail handling: four or five fellows, at least, would have been necessary to take even a short sail with any degree of comfort or safety. And how often can you just round up four or five fellows for a quick sail? She was not young, either, and needed some reworking here and there. And Lord knows she needed a motor. So she would have been costly. You see how the cold calculations begin to add up.

Interesting Features

There were several other interesting features. She was heavily rigged to thrash along in her native fjords and the Atlantic, but she was absolutely devoid of

anything resembling a winch. Perhaps this is standard rigging for Scandinavian 8-meters, I don't know. But the absence of winches posed some puzzles. The mainsheet rig worked all-right, with the usual double block at the end of the boom, etc.

The hoisting of the mainsail was a different story, though. Getting it down was a bit sticky, too, since there was no downhaul. The jib sheets presented no problems — they were plain impossible. I can visualize some cumbersome tackle arrangements whereby those sheets could have been trimmed, but at best such trimming must have been a busy, busy procedure. About her propulsion: she was, as I've said, all sail, but she had on board two 20-ft sweeps. There were two metal devices, located respectively on the port bow and starboard quarter, into which fitted, by cunning design, two specially made oarlocks. You may be beginning to get the picture, but look a bit more sharply. Can you see the consternation on the part of cynical colleagues, already half convinced of the inherently mad aspects of this sailing business, when they beheld us sculling along like slaves in a galley? Have you ever rowed an 8-meter?

But the freedom of fancy dies hard, if at all. After weeks of preparation, and eons of anticipation, we loaded the car and a trailer with all manner of gear and set out for New Orleans. We were going to sail her home from there, with a friend bringing the car back. As usual we were pressed for time; our schedule had already been postponed a week by bad weather. Now the weather bureau promised a fair 48 hours with prevailing light southeasterly breezes.

O, perfidy! At the last moment one of the crew had been unable to go, and another fellow was invited. I did not know him and learned only when we were half way to New Orleans that he had never been on a sail boat before. As part of being short-sighted, we were short-handed.

We Were Off!

The 14-ft skiff with outboard motor that we had brought along as our source of power was lashed alongside *Liv,* and with its aid we cleared the harbor. Meantime we wrestled with the halyards and could again marvel at the expanse of canvas that was the mainsail.

Below deck, the usual accessories for such a voyage bulged almost to the cabin top. The food and water; the sleeping bags and mattresses; a jumble of clothing and boots; the little stove, with its pots, pans, dishes; up forward the anchors and lines; extra lights, batteries, a box of tools, charts in a rack; the fenders, life preservers, compass, fire extinguishers — on and on, a great mass of material, each item of interest, designed for a specific purpose — the equipment aboard a boat can reach staggering proportions, and yet each part has a function that contains a degree of necessity.

A certain utilitarian charm pervades each of these objects; it is just the right thing to do the proper job if you but use it correctly. We had stored all this in a hurry, with some thought but no meticulous attention to where every shackle and shoe should be placed. We had just bought our boat from her previous owner. We had waved goodbye to the friend who was taking the car back home; he leaned against the light on the pier, wistful but skeptical and said, "She's even bigger at night — have a fine trip." It was just midnight. The outboard shoved us along, a mere suggestion of a breeze filled the sails gently.

She was ours, and we were off!

A half-mile from the weather shore allowed the zephyr to become a trifle more definite, so we dropped the skiff on a tow and with the outboard silenced could listen to the subdued murmur of ripples and splashes as *Liv* moved northeasterly across across the lake. Fog became thicker and the shore lights, obscured now by distance as well as fog, glimmered as diffuse patches, growing more dim and finally vanishing. The running lights were a faint glow, beyond which one could see nothing.

The silence and darkness were almost complete. Drifting like this gives a distinct sense of insubstantiality: deprived of customary visual and auditory stimuli one is drawn closer to his boat, the only actual object apparent in the present state of detachment. And this is good, for in our life on land we tend to become diffuse in our aims, ensnared in many a trap; here we can cleave to our boat, which is of a single purpose, which is solid and genuine, which is comfortingly alive.

The Damp and the Chill

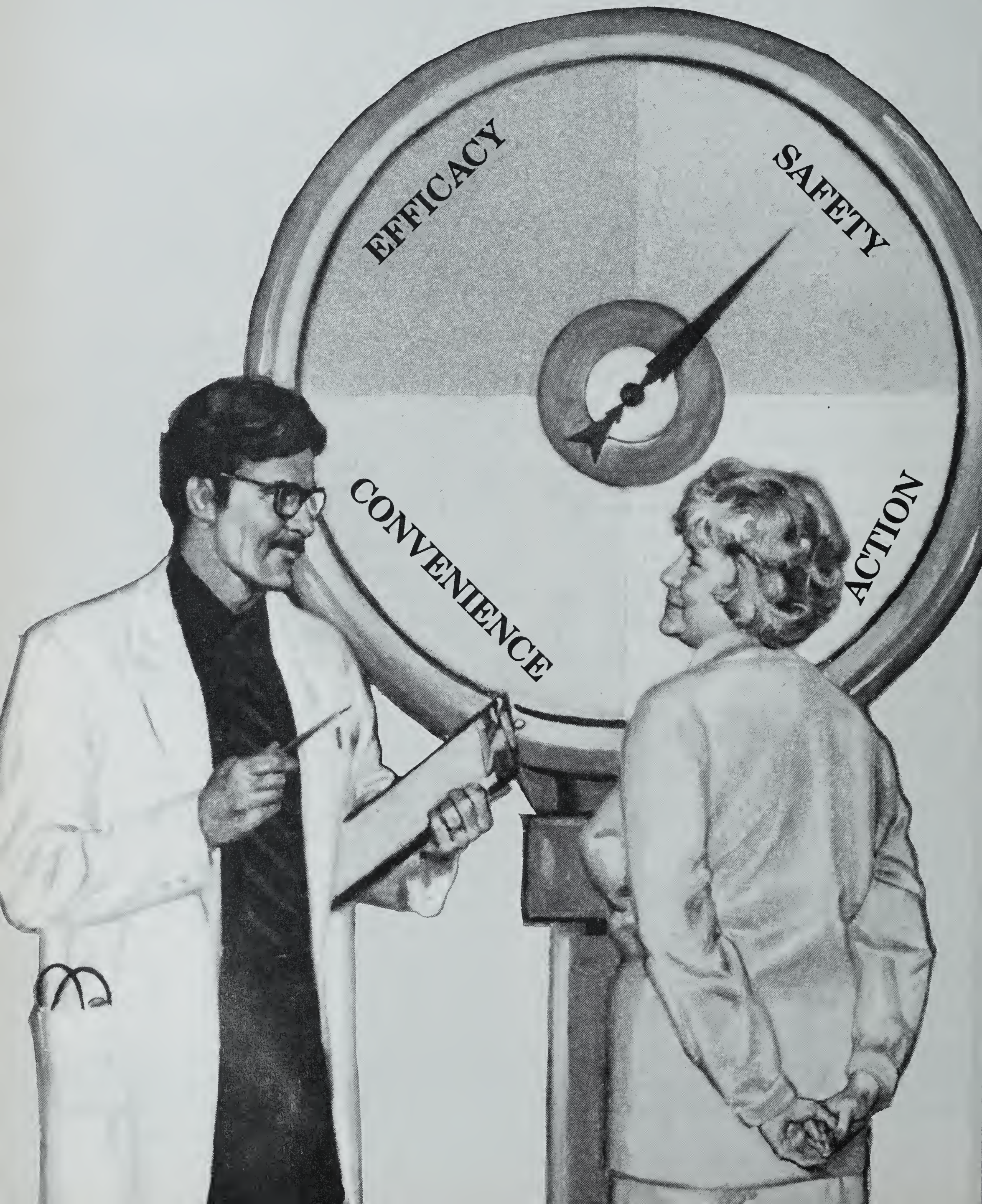
Even though it was February, the cabin, lit feebly by a single oil lamp, was warm and we had the forward hatch open for ventilation. On deck everything dripped and the dampness was chilly and penetrating. It had been a long, hard day, with the accompanying excitement making it no less exhausting. We crept steadily along, bound for the Rigolets, the passage between Lake Ponchartrain and Mississippi Sound. Our wind remained light, constant; we sank into a watchful torpor, but managed some catnaps. Time slipped away, and *Liv* dreamed she was in Skagerrak.

Pallid daybreak brought a wind that breathed in puffs, each puff of increasing pressure, and each puff backing about 10 degrees until soon a 25-mph nor'wester was churning the lake. Taking the helm of a good-sized, fast, heavy displacement boat on a reach in a strong breeze imparts the sensation of a personally controlled grandiose event.

The feeling of the surge and roll of the hull; the sight of the taut lines, streaming deck, and straining sails; the different adjustments in your balance to conform to her different movements; the sound of the water reaching up to her, being dashed aside, and then the urgent, rejuvenating spray — these feelings reach you through

continued on page 12

When your overweight patients seek your help with a weight reduction plan...

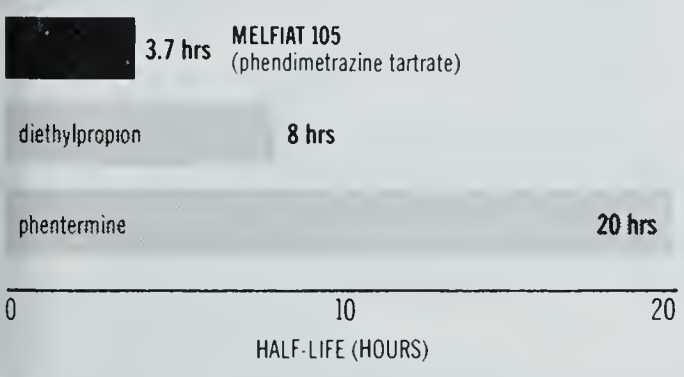


The benefits will outweigh the risks when you prescribe MELFIAT® 105

Because MELFIAT 105 effectively controls appetite.
MELFIAT 105 (phendimetrazine tartrate), an effective anorexiant, provides the appetite control overweight patients often need to begin a successful program of weight reduction. And the positive results of initial short-term therapy with MELFIAT 105 can help motivate them to a lifelong commitment of weight control.

Because MELFIAT 105 has a 3.7 hour half-life and low abuse potential.
Therapeutic efficacy combined with a short half-life and minimal abuse potential make MELFIAT 105 the drug of choice in the treatment of exogenous obesity. Because MELFIAT 105 has a short half-life, it minimizes drug accumulation and helps to eliminate such effects as disturbed sleep patterns. And, because MELFIAT 105 has significantly lower abuse potential than the amphetamines; there's less risk to your patients. According to a NIDA (National Institute on Drug Abuse) report, phendimetrazine appears to be the least abused anorexiant when compared to phentermine and diethylpropion.[1]

Half-life comparison of MELFIAT 105 and other anorexiants[2]



Because MELFIAT 105 is in a sustained-release capsule.
MELFIAT 105 provides your patients with continuous drug delivery for appetite control that lasts throughout the day and helps to eliminate compulsive snacking and overeating at meals. In addition, the sustained-release capsule form maintains more constant blood levels of MELFIAT 105...without peaks and valleys.

Because MELFIAT 105 offers convenient, once-a-day dosage.
MELFIAT 105 is available in a convenient capsule containing 105 mg. The simple morning dosage regimen is designed to encourage compliance, minimizing the chance of missed doses and assuring optimum therapeutic results.

Because MELFIAT 105 is from Reid-Provident Laboratories, Inc.
Reid-Provident has the highest standards of quality to assure that only the finest products reach you. An advisory board of research scientists, physicians, pharmacists, and other technical staff continually review existing products and new product proposals to make sure that the latest pharmaceutical technology is used in their design and manufacture. That's because Reid-Provident is committed to you and your patients.

For more information please write to
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640 Tenth Street, N.W.
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MELFIAT® 105 UNICELLES® C III
(phendimetrazine tartrate) Sustained-Release Capsules 105 mg

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MELFIAT® 105 UNICELLES® C III
(phendimetrazine tartrate) 105 mg Sustained-Release Capsules

INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.
Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
Allergic: Urticaria.
Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear sustained-release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.

Reid-Provident Laboratories, Inc.
Atlanta, Georgia 30318

all modalities of perception, telling you that you are a palpitating figure in a thrilling process.

Unless one is an ineffable clod he is bound to be impressed. We were duly impressed, for *Liv* was really rolling now. A wave would smash under her port quarter, pick her up with a compelling thrust, and foam away from her starboard bow. She hustled along, heeled moderately, pitching not a bit, smashing through one of the larger than usual seas with an authoritative air of magnificent power. It was raining hard.

Some Jeopardy

Some jeopardy is often present regardless of how it may be depicted. It may be narrated in an off-hand fashion, it may be presented only through implication. Perhaps the spice of the danger has an allure of its own in any activity. Maybe the exhilaration of living is enchanced by well-chosen chances. Anyway, the precarious situation we faced was dead ahead and clearly seen.

Stark and thousand-legged stretched the railway bridge, half a mile away through the driving rain. We were headed almost due east; with the wind continuing strong from the northwest our course was a straight shot through the swing span and into the Rigolets. Why not take advantage of this pressing wind and hurry home?

To be sure, bridges are tricky things, potentially deadly for boats, especially sail boats; the wind always is perverse around bridges, being deflected every which way by the structure itself and the land masses it usually connects; currents are often funnelled into greater velocity through the waterways that the bridge crosses; and there often is an increased bottleneck produced by the lack of comprehension, one of the other, between the mental processes of skippers and bridge tenders.

So we could have doused sail and dragged ourselves through with the outboard, or — but the post mortems are long over, and the results ashes in our mouths — we could have just stayed home in the first place, and been far more comfortable — if that had been our aim.

So *Liv* raced for the bridge, everything tight and wet and blowing. Through the glasses we saw the bridge tender, in response to our horn, leave his small shelter by the tracks and climb up to the control house of the bridge. His slicker was glistening with rain and flapping in the wind. We drove forward, each wave a successive crescendo, pulsating its energy through our boat and us. That bridge tender, vanished now into his control cage up in the girders, must have stopped to read the paper for the span showed no sign of moving.

It became apparent, as the distance rapidly decreased and that infernal bridge stayed motionless, crouched in candid decoy, that we would never clear it on this pass, and must go about.

Hard-a-lee!

So, ''Hard-a-lee!'' Down went the helm, we trimmed as she went, and with no hesitancy at all *Liv* spun up into the wind. And why shouldn't she? A strong wind and moderately heavy sea were this lady's cup of tea, to be taken in hand with a graceful flourish. Up, up she went, haughtily sure of herself, proud of her strength — and then she stopped, not quite in the wind's eye.

For as she had come round and into the wind we had, of course, freed the lee jib sheet, and now that sheet in its frantic thrashing, had snarled itself, somehow, somewhere (remember? — no winches, just our own jury-rigged, awkward tackle for handling those jib sheets). The instant the sheet fouled, *Liv,* with her jib again full, had been tripped in mid-stride.

Her bow wavered in its swing; she was struck with uncertainty — what fool thing were these men doing? Run, man, madly over the cabin top, over the foredeck, and cut that jib sheet! No time to try to clear its tangle, just cut it, and quick, quick! It was done; the knife slashed, the iron-hard sheet parted, and again the jib was free to snap like a guidon in a cavalry charge.

You have to perform such a maneuver with accuracy; the separate component actions all have to be executed correctly, for the success of the next-to-occur action is contingent upon the success of the previous one. Unless all the actions succeed, the less the chance of success of the entire process. And we had lost our chance. In the flashing interval required to cut that sheet *Liv* had lost her momentum and was then knocked further off by the sea and the wind itself. If the sheet hadn't fouled, if, if — ''one shade the more, one ray the less.''

Inopportune

She lurched right in the wind now, swung drunkenly through the wind onto the starboard tack, slowly, staggeringly tried to get her feet under her — pay off, fill her up, get her moving, for that bridge is now ominously close, with the current clawing its demon pull. Whether she could have fought her way out of that tight corner we will never know, for at that devastatingly inopportune moment the bridge tender (Ah, man, where were you so long, so long?) put the swing span into motion.

The end of the span moved relentlessly in an arc towards the stern of *Liv;* the span struck the back stay and turned her around alongside the girders. All this had occurred with our shouts to the bridge tender lost in the grinding of the machinery of the bridge; our cries were feeble, even in our own ears, amid the rain and hard wind.

Now the lower port spreader caught against a member of the bridge. *Liv* heaved in the rough sea, the spreader broke and instantaneously the top half of the mast, deprived thus of its support, snapped off and

crashed onto the deck with an accompanying incredible welter of canvas, lines, and stays.

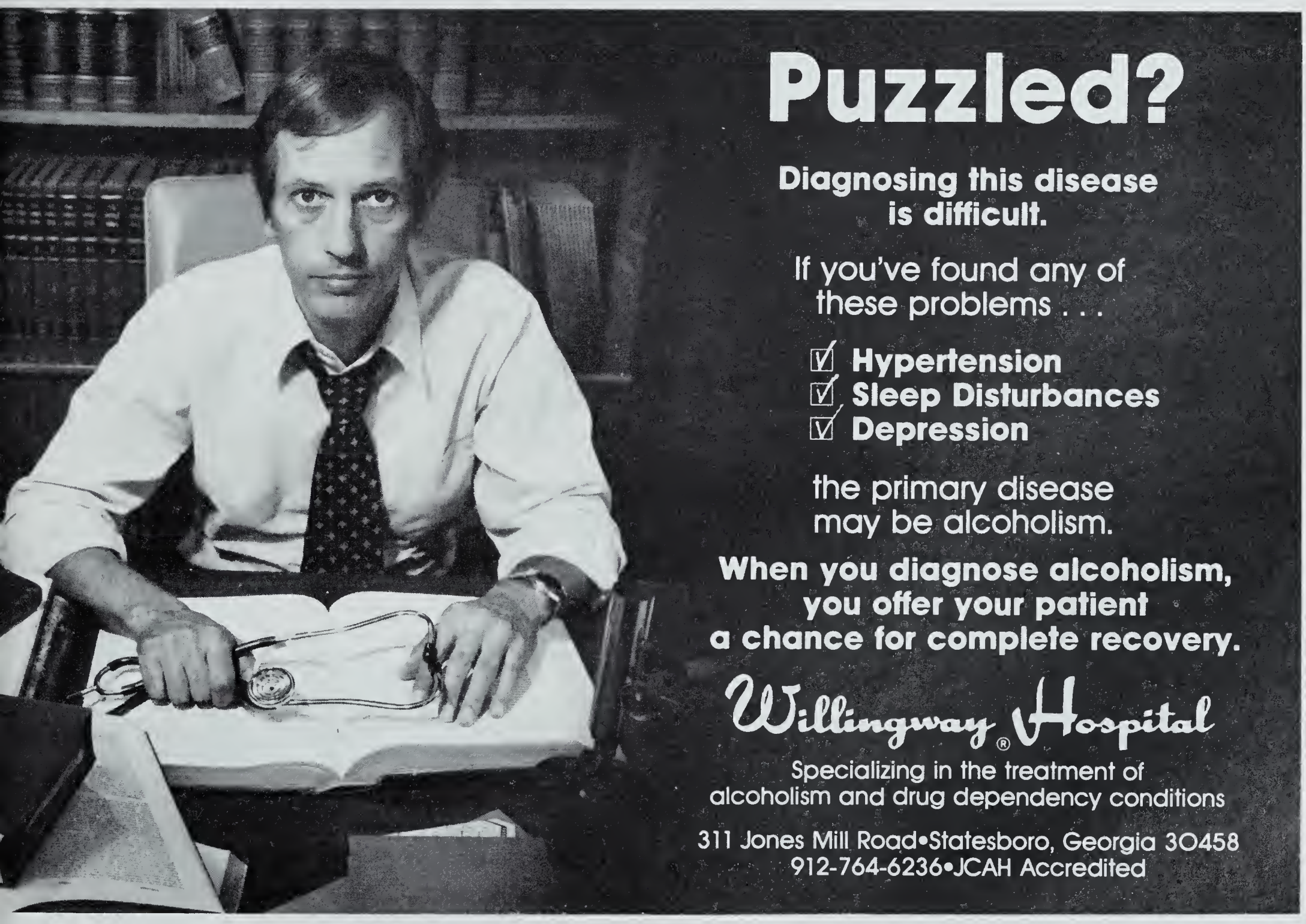
Mortally Wounded

Desperately wounded now, totally out of control, *Liv* fell off the span under the urging of the seas, and slammed into the pilings that formed the boundaries of the span entry. With each wave she hammered her port side viciously. The tiller swung frantically from side to side; the boom and the top half of the mast, now in a new and unhappy location, flailed the cabin top, the cockpit coaming, each other; all the attached canvas was either blowing straight to leeward or pinned to the deck beneath the jumble of wire stays and lines.

We stood on the catwalk atop the pilings and tried to pull her off the windward side of the piles; the lines might as well have been attached to the piles themselves for all we could budge her. Trapped there by her own weight, plus the full weight of the wind and sea, she was immovable. Immovable, except, of course, by the sea itself, which was her cradle, which was now destroying her. In only a few minutes under that battering she knocked holes in her side, and in only a few minutes more she filled and sank slowly.

Uninjured physically we stood on the catwalk (the tender didn't close the span for an hour) and with the wind blasting us almost off our perch, forlornly contemplated a desolate scene: a froth-flecked sea stretched to the horizon, interrupted by the topmost two ft of the lower section of the mast protruding above the water, its splintered end an accusing finger pointed at us.

But to repeat: the freedom of fancy dies hard, if at all; "If my barque sinks, 'tis but to another sea." *Liv* was reborn, and sails again. Not for us, though. The image had been shattered, the shrine desecrated, the bird flown. We could not recapture her. Perhaps she would not have let us. ⊡



NOW THERE IS A BETTER ALTERNATIVE TO STOOL EXAMS. ENTERO-TEST.

ENTERO-TEST® Adult, and Pediatric, a nylon line coiled inside of a gelatin capsule. The Pediatric string is 90cm and the Adult string is 140cm. Both capsules are designed to retrieve duodenal contents without intubation.

ENTERO-TEST® has the following advantages:

- Rapid
- Accurate
- Safe
- No Radiation
- Outpatient and Inpatient Use

Studies have confirmed the following applications for the Entero-Test:

PARASITES:

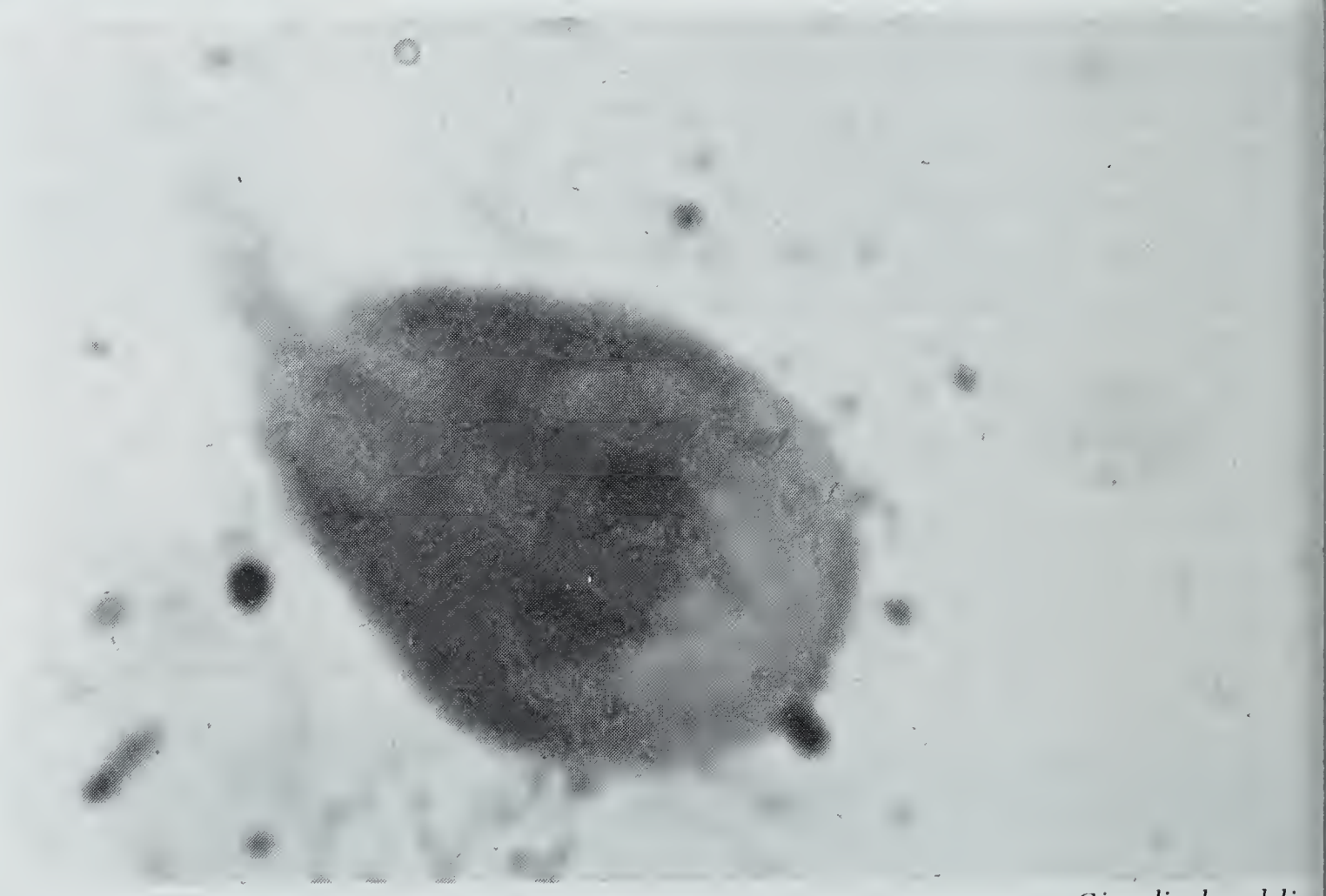
Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include Giardia lamblia (motile trophozoites), Strongyloides stercoralis (larvae and/or eggs in advanced stages of development), Clonorchis sinensis (eggs), Fasciola hepatica (eggs), Trichostrongylus orientalis (eggs), and Isospora (coccidia).

SALMONELLA TYPHI:

Multiple stool exams cultured over several weeks or duodenal intubation are the most commonly used procedures. The Entero-Test is as efficient as intubation but simpler and more comfortable. New studies have further confirmed superior applicability over other procedures.

SMALL INTESTINAL MICROFLORA (Bacterial overgrowth):

Chronic Diarrhea caused by anaerobic and aerobic bacteria in infants and children was easily identified using the Entero-Test. The string test was comparable to or better than duodenal aspirate in all cases.



Giardia lamblia

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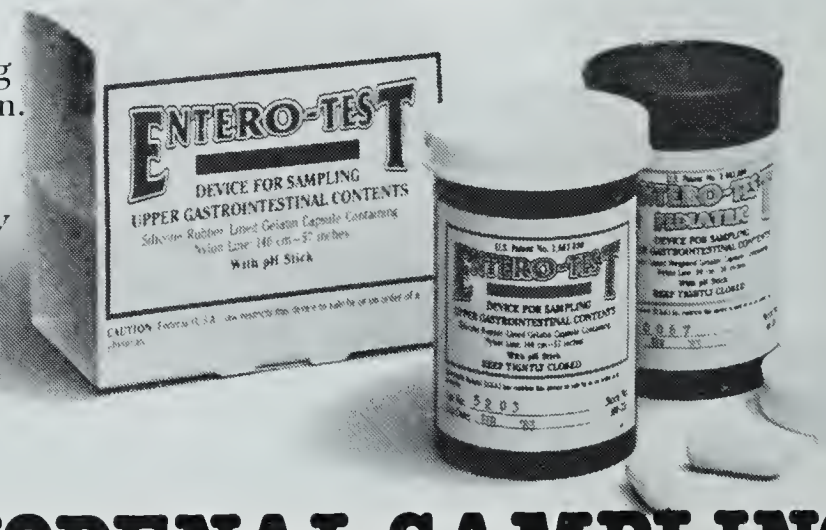

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Cardinal's Bark

by William L. Smith, M.D.

In 1638 the Countess of Chinchon lay ill with an "obstinate, intimittent fever." Don Lobez de Canizares, a Spanish official at Toxa, Ecuador, had been cured by someone, now unknown, in 1630. The successful treatment was the administration of the bark of a native tree. De Canizares suggested this treatment to the Countess's husband, the Viceroy of Peru. Needless to say, the treatment worked. The fever was Malaria, probably vivax. The bark and tree were named Cinchona. The active alkaloid was quinine.

By 1639 the drug was in Spain and by 1640 was known throughout Europe. The Jesuits were primarily responsible for bringing the bark to Europe and later transplanting the trees to various parts of the world. The cardinals took much in the credit and it became known as Jesuits' or Cardinal's bark.

The discovery of alkaloids in opium was followed in 1820 by the discovery of quinine and cinchonine in cinchona. The liquid from the bark is used in vulcanizing rubber.

Of the family Rubiaceae, there are some 36 species of cinchona, and several hybrids are known. Some yield very high percentages of alkaloid, up to 13% in the parinchina. These were introduced into the East Indies. The growth of the cinchona around the world follows the same patterns as the concentrations of the malarias. So nature put the aid in reach of most sufferers of malaria.

Quinine remained the only drug for the control of malaria until plasmoquine was introduced by Mühlens in 1926.

In December 1904 Edward Jepson reported in the *British Medical Journal* as follows: "If a few grains of quinine be administered within 24 hours before an operation it will be found that the heart's action is improved and maintained right through the operation, regardless even, of the amount of anesthetic used."

Seventeenth-century engraving of the cinchona plant, the bark of which was used in the treatment of malaria. Later, this was found to contain quinine.

(The favorite anesthetic of that day was chloroform with its potential dangers.)

The lady from Peru launched a famous, worldwide therapeutic agent that has endured until the present day.

Statutory Reporting Requirements of Physicians

Wendell R. Morgan
MASA General Counsel

The laws of the State of Alabama impose certain requirements for reports related to the practice of medicine from physicians who practice within the state. This article attempts to collect and reproduce the pertinent portions of those statutes.

Not included are general requirements imposed upon the conduct of all businesses and professions in such areas as corporate matters and taxation. References, unless otherwise specified, will be to the *Code of Alabama, 1975,* as amended in the 1981 Cumulative Supplement.

In virtually every instance, the statute imposing the reporting requirement is not specific with respect to the exact form of the report or to the precise office to which it is directed. Many reports are required to be submitted to the State Board of Health or the State or County Health Officer.

Due to the wide diversity in the organization of public health at the county level, it is beyond the scope of this article to attempt to identify each recipient of the required reports. For information concerning reports directed to the State or County Health Officer, the State Board of Health, or the State Department of Public Health, contact Mr. Grover Dick, Alabama Department of Public Health, Room 200, State Office Building, 501 Dexter Avenue, Montgomery, Alabama 36130, Phone, (205) 832-3204.

The reports required by statute can be generally grouped into one of the following categories: (1) Child and Adult Abuse, (2) Reportable Diseases and/or Tests for Diseases, (3) Controlled Substances and Devices, (4) Births and Deaths, and (5) Reports related to Professional Conduct.

A summary of the statutory reporting requirements, in chart form, is provided for ease of reference. This chart can easily be incorporated into an Office Practice and Procedure Manual and should be beneficial to office staff in identifying the areas of practice that may generate a required report.

The following statutes (or excerpts) outline the physicians' statutory reporting requirements:

CHILD ABUSE

§ 26-14-1. Definitions.

For the purposes of this chapter, the following terms shall have the meanings respectively ascribed to them by this section:

(1) ABUSE. Harm or threatened harm to a child's health or welfare. Harm or threatened harm to a child's health or welfare can occur through nonaccidental physical or mental injury, sexual abuse or attempted sexual abuse or sexual exploitation or attempted sexual exploitation. ''Sexual abuse'' includes rape, incest and sexual molestation as those acts are defined by Alabama law. ''Sexual exploitation'' includes allowing, permitting or encouraging a child to engage in prostitution and allowing, permitting, encouraging or engaging in the obscene or pornographic photographing, filming or depicting of a child for commercial purposes.

(2) NEGLECT. Negligent treatment or maltreatment of a child, including the failure to provide adequate food, medical treatment, clothing or shelter; provided, that a parent or guardian legitimately practicing his religious beliefs who thereby

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*Contraindicated in pregnant women and in persons who have shown hypersensitivity to the drug.

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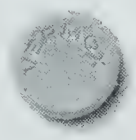

DESCRIPTION VERMOX (mebendazole) is methyl 5-benzoylbenzimidazole-2-carbamate.

ACTIONS VERMOX exerts its anthelmintic effect by blocking glucose uptake by the susceptible helminths, thereby depleting the energy level until it becomes inadequate for survival. In man, approximately 2% of administered mebendazole is excreted in urine as unchanged drug or a primary metabolite. Following administration of 100 mg of mebendazole twice daily for three consecutive days, plasma levels of mebendazole and its primary metabolite, the 2-amine, never exceeded 0.03 μg/ml and 0.09 μg/ml, respectively.

INDICATIONS VERMOX is indicated for the treatment of *Trichuris trichiura* (whipworm), *Enterobius vermicularis* (pinworm), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), *Necator americanus* (American hookworm) in single or mixed infections. Efficacy varies as a function of such factors as pre-existing diarrhea and gastrointestinal transit time, degree of infection and helminth strains. Efficacy rates derived from various studies are shown in the table below:

	Whipworm	Common Roundworm	Hookworm	Pinworm
cure rates				
mean	68%	98%	96%	95%
(range)	(61-75%)	(91-100%)	—	(90-100%)
egg reduction				
mean	93%	99.7%	99.9%	—
(range)	(70-99%)	(99.5%-100%)	—	—

CONTRAINDICATIONS VERMOX is contraindicated in pregnant women (see Pregnancy Precautions) and in persons who have shown hypersensitivity to the drug.

PRECAUTIONS *PREGNANCY:* VERMOX has shown embryotoxic and teratogenic activity in pregnant rats at single oral doses as low as 10 mg/kg. Since VERMOX may have a risk of producing fetal damage if administered during pregnancy, it is contraindicated in pregnant women.

PEDIATRIC USE: The drug has not been extensively studied in children under two years; therefore, in the treatment of children under two years the relative benefit/risk should be considered.

ADVERSE REACTIONS Transient symptoms of abdominal pain and diarrhea have occurred in cases of massive infection and expulsion of worms.

DOSAGE AND ADMINISTRATION The same dosage schedule applies to children and adults. The tablet may be chewed, swallowed or crushed and mixed with food. For the control of pinworm (enterobiasis), a single tablet is administered orally, one time. For the control of common roundworm (ascariasis), whipworm (trichuriasis), and hookworm infection, one tablet of VERMOX is administered, orally, morning and evening, on three consecutive days. If the patient is not cured three weeks after treatment, a second course of treatment is advised. No special procedures, such as fasting or purging, are required.

HOW SUPPLIED VERMOX is available as chewable tablets, each containing 100 mg of mebendazole, and is supplied in boxes of twelve tablets.
VERMOX (mebendazole) is an original product of Janssen Pharmaceutica, Belgium.

US Patent 3,657,267
December 1979

Committed to research...
because so much remains to be done.

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does not provide specified medical treatment for a child, for that reason alone, shall not be considered a negligent parent or guardian; however, such an exception shall not preclude a court from ordering that medical services be provided to the child, where his health requires it.

§ 26-14-3. Mandatory reporting.

(a) All hospitals, clinics, sanitariums, doctors, physicians, surgeons, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, school teachers and officials, peace officers, law enforcement officials, pharmacists, social workers, day care workers or employees, mental health professionals or any other person called upon to render aid or medical assistance to any child, when such child is known or suspected to be a victim of child abuse or neglect, shall be required to report, or cause a report to be made of the same, orally, either by telephone or direct communication immediately, followed by a written report, to a duly constituted authority.

(b) When a report is made to a law enforcement official, such official subsequently shall inform the department of pensions and security of the report so that the department can carry out its responsibility to provide protective services to the respective child or children. (Acts 1965, No. 563, p. 1049, § 1; Acts 1967, No. 725, p. 1560; Acts 1975, No. 1124, § 1.)

ADULT ABUSE

§ 38-9-2. Definitions.

For the purposes of this chapter, the following terms shall have the meanings respectively ascribed to them by this section:

(1) ADULT IN NEED OF PROTECTIVE SERVICES. A person 18 years of age or older whose behavior indicates that he is mentally incapable of adequately caring for himself and his interests without serious consequences to himself or others, or who, because of physical or mental impairment, is unable to protect himself from abuse, neglect or exploitation by others, and who has no guardian or relative or other appropriate person able, willing and available to assume the kind and degree of protection and supervision required under the circumstances.

(6) ABUSE. The willful infliction of physical pain, injury or mental anguish or the willful deprivation by a caretaker or other person of services necessary to maintain mental and physical health.

(7) NEGLECT. The failure of a caretaker to provide basic needs such as food, shelter and health care for the person unable to care for himself; or the failure of the person to provide these basic needs for himself when the failure is the result of the person's mental or physical inability.

(8) EXPLOITATION. An unjust or improper use of another person or another person's resources for one's

own profit or advantage or for the profit or advantage of another person.

§ 38-9-8. Reports by physicians, etc., of physical abuse, neglect or exploitation — Required; method of reporting; contents.

(a) All physicians and other practitioners of the healing arts having reasonable cause to believe that any adult protected under the provisions of this chapter has been subjected to physical abuse, neglect or exploitation shall report or cause a report to be made as follows:

(1) An oral report, by telephone or otherwise, shall be made immediately, followed by a written report, to the county department of pensions and security or to the chief of police of the city or city and county, or to the sheriff of the county if the observation is made in an unincorporated territory.

(2) Within three days following such oral report, an investigation shall be made by the county department of pensions and security or the law enforcement official, whichever receives the report, and a written report prepared which will include the following:

a. Name, age and address of such person.

b. Nature and extent of injury suffered by such person.

c. Any other facts or circumstances known to the reporter which may aid in the determination of appropriate action.

(b) All such reports prepared by a law enforcement official shall be forwarded to the county department of pensions and security within 24 hours. (Acts 1977, No. 780, p. 1340, § 6.)

REPORTABLE DISEASES

§ 22-11-1. Enumerated.

The State Board of Health shall designate the diseases and disabilities which are notifiable. The diseases so designated by the Board of Health are declared to be notifiable diseases of epidemic potential and a threat to the health and welfare of the public, and the occurrence of cases shall be reported as provided in this chapter. This Act shall in no way affect any provision in Title 22, Chapter 16, nor shall the State Board of Health include any disease listed in Chapter 16 as a designated disease in this chapter. The State Board of Health shall divide the notifiable diseases into groups as follows:

(1) Group A. Emergency Reporting. Diseases designated as Group A shall be reported to the County Health Officer and the State Health Officer within twelve (12) hours of diagnosis, by telephone, telegraph, or in person. Said report shall, at a minimum, include the name of the disease or disability which is diagnosed, the name and address of the person having said disease, the current location of said person, and the date of onset or date of diagnosis of said disease or disability.

(2) Group B. Diseases Notifiable Within Seven (7) Days. Diseases and disabilities declared to belong to Group B shall require notification in writing, on forms to be provided by the State Board of Health, of the occurrence of the case of said disease to the County Health Officer, the State Health Officer, or their designee, within seven (7) days of such diagnosis.

(3) Group C. Diseases Reported By Number Only. Diseases designated as Group C shall be reported on forms provided by the State Board of Health to the County Health Officer, the State Health Officer, or their designee, on a weekly basis. Said report to contain as a minimum the number of cases of said disease or disability seen by the reporting health care provider within the seven (7) day period prior to the report.

§ 22-11-2. Report by physicians required; form of report.

Each physician practicing in the state of Alabama who treats or examines any person having, or suspected of having, any notifiable disease shall report such cases of notifiable disease in the manner designated in Section 1 of this chapter. Said written report shall be upon such forms, and shall contain such matter, as may be provided for from time to time by the rules and regulations of the state board of health. All medical and statistical information and reports required by this title shall be confidential and shall not be subject to public inspection, subpoena, or admission into evidence in any court except upon express order of the court or upon written consent of one having a direct and tangible interest therein. No provision of this section shall be interpreted to prevent the publication of statistical reports or other summaries provided that said reports or summaries do not identify individual persons.

Note: Sections cited from most recent amendment in Act No. 81-439 enacted May 7, 1981. The State Committee of Public Health adopted rules and regulations pursuant to Act No. 81-439 on November 18, 1981. Copies available from the State Department of Public Health.

BIRTHS

§ 22-9-11. Records and reports of inmates and births and deaths in institutions.

All superintendents, managers or other persons in charge of hospitals, almshouses, lying-in or other institutions, public or private, to which persons resort for treatment of diseases or confinement or are committed by process of law shall forthwith make a record of all the personal and statistical particulars relative to the inmates in their institutions which are required in the forms of the certificate provided by this section, as directed by the state registrar, and thereafter, such record shall be by them made for all future inmates at the time of their admittance. In the case of persons

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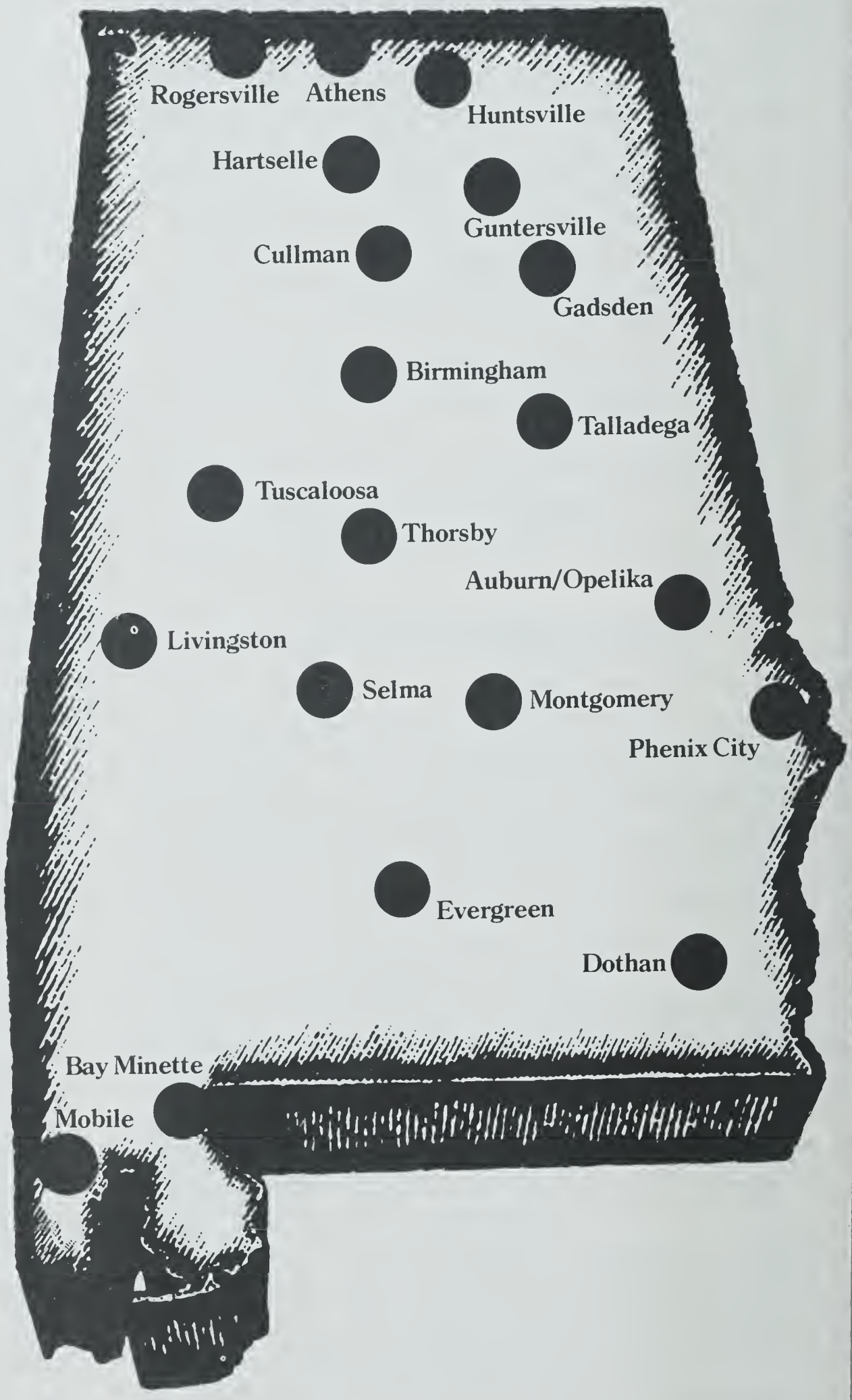

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admitted or committed for treatment of disease, the physician in charge shall specify, for entry in the record, the nature of the disease and where, in his opinion, it was contracted. The personal particulars and information required by this section shall be obtained from the individual himself, if it is practicable to do so, and, when they cannot be so obtained, they shall be obtained in as complete a manner as possible from relatives, friends or other persons acquainted with the facts. Furthermore, all superintendents, managers or other persons in charge of hospitals, almshouses, lying-in or other institutions, public or private, to which persons resort for treatment of diseases or confinement or are committed by process of law shall keep a record of all births, stillbirths and all deaths within their institutions and, on the fifth day of each month, shall report such births, stillbirths and deaths for the preceding month, on such form as the state board of health shall provide, to the county health officer or, in counties without a county health officer, to the state registrar. If there are no births, stillbirths or deaths in any month, a report stating that fact shall be made on the fifth day of the following month, on such form as the state board of health shall provide, to the county health officer or, in counties without county health officers, to the state registrar. Nothing in this section shall be taken to relieve the undertaker or other persons having charge of burial or removal of his responsibility to file a death certificate in accordance with section 22-9-75, or the responsibility of physicians or midwives to file birth certificates in accordance with section 22-9-30; provided, that each county health officer shall send said report of each birth, stillbirth and death for the preceding month of each superintendent, manager or other person in charge of hospitals, almshouses and lying-in or other institutions, public or private, to the state registrar on, or before, the tenth day of each month. (Acts 1919, No. 658, p. 909; Code 1923, § 1081; Acts 1927, No. 640, p. 774; Acts 1935, No. 443, p. 918; Code 1940, T. 22, § 36.)

§ 22-9-30. Registration of births — Required.

The birth of each child born in this state shall be registered as provided in this article. Within five days after the date of a birth there shall be filed with the local registrar of the registration district in which the birth occurred a certificate of such birth, which certificate shall be upon the form adopted by the state board of health, with a view to procuring a full and accurate report with respect to each item of information that may be required under section 22-9-31. The institution in which the child is born or, in the case where the child is not born in an institution, then the father or mother of the child, within five days after the date of such birth, shall report to the local registrar the fact of such birth. If the person reporting said birth is unable, by diligent inquiry, to obtain any item or items of information contemplated by section 22-9-31, the local registrar shall secure from the person so reporting, or from any other person having the required knowledge, such information as will enable him to prepare the certificate of birth contemplated in this section, and the person reporting the birth, or who may be interrogated in relation thereto, shall answer correctly and to the best of his knowledge all questions put to him by the local registrar, which may be calculated to elicit any information needed to make a complete record of the birth as contemplated by section 22-9-31; and the informant as to any statement made in accordance with this section shall verify such statement by his signature when requested so to do by the local registrar. In all such cases, the person reporting the birth shall collect the normal fee for a certified copy of the birth certificate from the mother or father, which fee shall be deposited with the local registrar of the registration district in which the birth occurred and which shall be forwarded to the state registrar when a complete record of the birth is obtained or when the local registrar files his monthly report, and the state registrar shall forthwith issue a certified copy of the birth certificate to the mother or father of the child. The issuance of a certified copy of the birth certificate by the state registrar may not apply to births where adoption or illegitimation is indicated or where the infant's death occurred a short time following the birth, unless the certificate is requested by the father or mother.

A receipt for a certificate filed shall be issued to any physician, midwife or head of a household by the local registrar upon demand. The absence of a certificate of birth of any child from the files of the state registrar shall be prima facie evidence that a certificate for said birth was not filed. (Acts 1919, No. 658, p. 909; Code 1923, § 1077; Code 1940, T. 22, §32; Acts 1979, No. 79-602, p. 1066.)

§ 22-9-31. Same — Form and manner of preparation.

All certificates of live birth shall be written legibly in unfading ink, and no certificate shall be complete and correct nor accepted for filing that does not bear all of the items of information called for, or fully accounts for their omission. The certificate of birth shall contain such information, and in such form, as the state board of health may prescribe. The personal particulars called for shall be given together with the name of the informant. In case of plural births a separate certificate shall be made for each. If the child dies without a given name, the words, ''died unnamed'' shall be entered in the space provided for the name. If the live birth has not yet been named at the date of filing the certificate of birth, the space for the given name of the child shall be left blank, to be filled out subsequently by a supplemental report as provided in section 22-9-32. If the child is illegitimate no information relative to the father shall be entered. Any physician or other person who

attends an illegitimate birth may file the certificate of such birth directly with the state registrar of vital statistics, but such certificate must be filed with said official not later than the first of the month immediately succeeding the month of birth. In cases of legitimation in the manner prescribed by law, the state registrar, upon receipt of a proof thereof, shall prepare a new certificate of birth in the new name of the legitimated child. The evidence upon which the new certificate is made and the original certificate, if any, shall be sealed and filed. The certificate shall be signed by the attending physician or midwife with date of signature and address; if there was no physician or midwife in attendance, then by the father or mother of the child, householder, owner of the premises, manager or superintendent of public or private institution where the birth occurred or other competent person, whose duty it shall be to notify the local registrar of such birth. The local registrar shall enter the exact date of filing of the certificate in his office and the registered number of the birth attested by his official signature. (Acts 1919, No. 658, p. 909; Code 1923, § 1078; Code 1940, T. 22, § 33; Acts 1943, No. 492, p. 454, § 8.)

DEATHS

§ 22-9-71. Same — Certification of medical data.

The medical certification of cause and time of death shall be completed, signed and filed by the attending physician, if any; otherwise the medical certification shall be made and signed by the county health officer or coroner, as may be appropriate. The medical certification of the certificate of death shall be properly completed and returned to the local registrar within three days after receipt of the certificate. The attending physician shall certify the disease or condition directly leading to death, antecedent causes and conditions contributing to the death and such other medical data as may be required by the state registrar to properly classify the death. He shall also specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred, except deaths referred to the coroner. For the purposes of this section and sections 22-9-70 and 22-9-75, an attending physician is one who has medical knowledge of the deceased, or viewed the body, or last physician in attendance before death or a combination of the above. In the case of any death which occurs without medical attendance, the county health officer or coroner, when so notified by the funeral director or other person, shall investigate and make and file the certificate of death; provided, that if the county health officer suspects suicide, or is unable to ascertain the cause of death or finds circumstances which cause suspicion that the death was caused by the criminal act of another, he shall then refer the case to the coroner or other proper officer for his investigation and certification. The county health officer, coroner or other proper official whose duty it becomes to make the medical certificate shall state the name of the deceased, if known, the cause (disease) of death or, if an external cause, the means of death and whether (probably) accidental, suicidal or homicidal. It shall be the duty of the local registrar to secure the properly signed medical data on the certificate, except when secured by the funeral director. (Acts 1919, No. 658, p. 909; Code 1923, § 1072; Acts 1935, No. 444, p. 926; Code 1940, T. 22, § 26; Acts 1943, No. 492, p. 454, § 6; Acts 1971, No. 974, p. 1739, § 3; Acts 1973, No. 1001, p. 1533, § 4.)

FETAL DEATH

§ 22-9-72. Certificate of fetal death.

A certificate of every fetal death shall be filed with the local registrar of the district in which the fetal death occurs within three days after the occurrence is known; except, that a certificate shall not be required if the fetus has not advanced to, or beyond, the twentieth week of uterogestation. If the place of fetal death is not known, then the certificate shall be filed with the local registrar of the district in which the fetus is found. It shall be the duty of the attending physician or midwife to prepare a certificate of fetal death properly filled out on a blank provided by the state board of health. The attendant on a fetal death, physician or midwife shall sign the certificate and give his or her address and date of signature, together with such medical data pertaining thereto as he can furnish. In case of plural fetal deaths, a separate certificate shall be made for each child. If there is no attending physician or midwife, then it shall be the duty of the father or mother or manager of the premises or institution to prepare the certificate and to deliver same within three days to the registrar of the district in which the event took place. If there is interment of a stillborn child, the person in charge shall be responsible for filing the certificate. (Acts 1919, No. 658, p. 909; Code 1923, § 1070; Code 1940, T. 22, § 24; Acts 1943, No. 492, p. 454, § 4; Acts 1971, No. 974, p. 1739, § 1; Acts 1973, No. 1001, p. 1533, § 2.)

RABIES
(Excerpt from § 3-7-9)

§ 3-7-9. Confinement of animals which have bitten humans; failure of person having knowledge of person having been bitten to report same, etc.; liability of owner of confined animal for handling expenses; when biting animals may be destroyed and head submitted for examination; procedure as to sentry or guard dogs used in law-enforcement work.

It shall be unlawful for any person having knowledge that any person has been bitten by any such animal to refuse to notify promptly one or more of the officers mentioned in this section.

PHYSICIANS — PLEASE CLIP FOR FILING OR POSTING

Subject/Ref.	Prepared by	Submitted to	How Made/When Made	What Reported
Child Abuse § 26-14-3	Physicians and Hospitals	Police Chief or Sheriff or County Dept. of P & S	By phone and written follow-up	Non-accidental physical injury, sexual abuse, attempted sexual abuse
Adult Abuse §38-9-8	Physicians	Police Chief or Sheriff or County Dept. of P & S	By phone and written follow-up	Physical abuse, neglect, exploitation
Reportable Diseases § 22-11-2	Physicians	County and State Health Officer	Group A — telephone within 12 hours Group B — written within 7 days Group C — written within 7 days	As designated by State Board of Health
Births § 22-9-11	Hospitals, Physicians and Midwives	Local register of Registration District	Written report within 5 days	As prescribed in § 22-9-30
Deaths § 22-9-71	Attending Physician	Local register of the District	Written report within 5 days	Disease or condition causing death, day and hour of death, as prescribed by § 22-9-71
Fetal Death § 22-9-72	Attending Physician	Local register of the District	Written report within 3 days	Report only if fetus has advanced to or beyond twentieth week of uterogestation
Rabies § 3-7-9	Any person having knowledge	County Health Officer or Rabies Inspector	Promptly notify	Any person bitten by a member of the canine or feline family 3 months of age
Venereal Diseases § 22-16-2	Physician and Hospital Mgr.	County Health Officer	Immediately in writing	Name, age, address, etc. of patient, stage, date of onset and probable source
§ 22-16-11	Physician	Previous Physician or County Health Officer	14 days after last appearance	Failure to report for treatment
§ 22-16-12	Physician	Previous Physician or County Health Officer	5 days after scheduled appointment	Failure to report for treatment
Cancer § 22-13-10	Physician	State Board of Health	Maintained and submitted upon request	Information required on form furnished by County Health Officer
Radioactive Materials § 22-14-8	Persons licensed to possess radioactive materials or devices	State Board of Health	Maintained and submitted upon request	Receipt, transfer, and disposal of materials/ radioactive exposure of all persons for whom monitoring is required
Controlled Substances Inventories § 20-2-56 P.L. 91-513	All registrants with DEA & ASCS certificate	Maintained for 2 years by registrant	Schedule II inventory separately/Schedules III, IV & V separately or readily retrievable	Complete record of all stocks on hand every two years
Malpractice Judgments § 34-24-56	Physicians	Board of Medical Examiners	Within 30 days of each calendar year	Any final judgment or any settlement
Violations of Medical Practice Act § 34-24-361 (b)	All Physicians	Board of Medical Examiners or Medical Licensure Commission	Not specified	Any violation of Medical Practice Act by physician holding a certificate of qualification in Alabama
Professional Corporations § 10-4-226 § 10-4-230	Professional Corporations (Physicians)	Board of Medical Examiners	Initial notice immediately/annual statement before January 30th of each year	Name of corporation and names and addresses of shareholders
Change of Address § 34-24-338	Licensed Physicians	Medical Licensure Commission	Within 15 days	Change of address
PKU testing § 22-20-3	Physician or Administrative Officer of institution	State Board of Health, Clinical Laboratory	0-2 weeks from birth	As designated by the State Board of Health
Physician Disciplinary Actions § 34-24-59	Hospital Administration Officer or Professional Society of Physicians	State Board of Medical Examiners	Written report within 60 days	Professional ethics violations, medical incompetence, moral turpitude, drug or alcohol abuse

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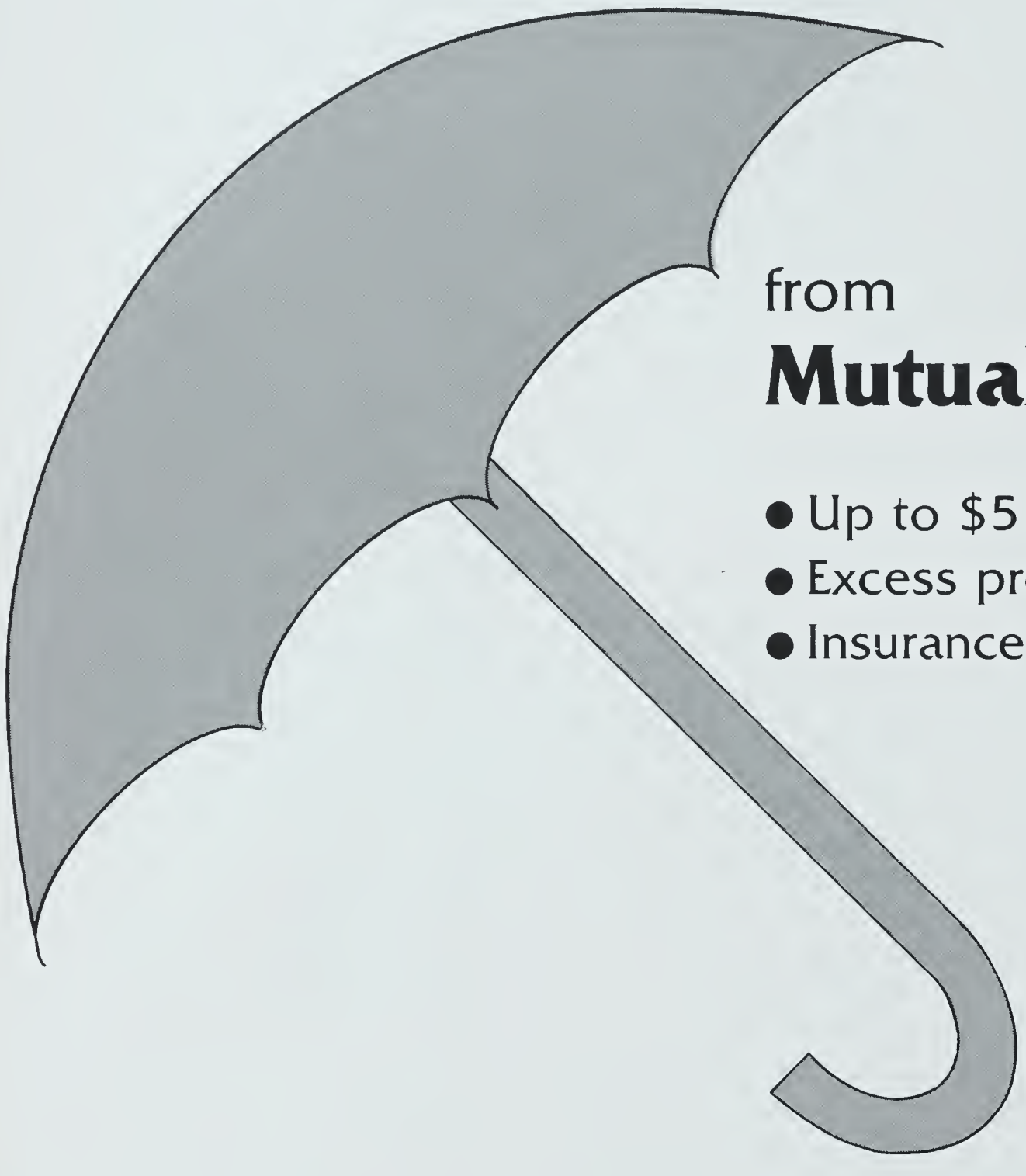

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VENEREAL DISEASES

§ 22-16-2. Duty of physicians and institutional managers to report.

Any physician who makes a diagnosis or treats a case of syphilis, gonorrhea, chancroid, lymphogranuloma inguinale or granuloma venereum and the superintendent or manager of a hospital or dispensary or penal or other institution in which there is a case of venereal disease shall report such a case immediately in writing to the county health officer, stating the patient's name or initials, the age, race, sex, marital status, address, the stage of the disease and occupation of such diseased person, the date, as near as it can be arrived at, of the onset of the disease and the probable source of infection, and the report shall be enclosed in a sealed envelope and sent to the county health officer. (Code 1923, § 1104; Acts 1939, No. 229, p. 369; Code 1940, T. 22, § 262.)

§ 22-16-11. Duty of physician to ascertain previous treatment by other physician.

Whenever a physician treats or examines a case of venereal disease, he shall inquire of and ascertain from the diseased person whether such person has theretofore consulted with or been treated by any other physician and, if so, to ascertain the name and address of the physician last theretofore consulted. The diseased person shall furnish this information. The physician, when the diseased person has theretofore received treatment, shall immediately notify by mail the physician theretofore treating such person of the change of physician, such notification to be made upon a form furnished for that purpose by the state board of health. Should the physician previously consulted fail to receive such notice within 14 days after the last appearance or treatment administered by him to such venereally-diseased person, such physician shall report to the county health officer the name and address of such venereally-diseased person. (Acts 1919, No. 658, p. 909; Code 1923, § 1108; Acts 1935, No. 444, p. 926; Code 1940, T. 22, § 266.)

§ 22-16-12. Record of consultation or treatment.

The physician treating any person infected with a venereal disease shall make and keep an accurate record of each and every time such person so diseased is seen for the purpose of consultation or treatment, and each and every person so seen shall be instructed by the physician as to the day or date on which said person so diseased shall be expected to be next seen for the purpose of treatment or consultation. If, after five days from the day or date so specified, the person so instructed has not returned to or been seen by the physician responsible for the treatment, said physician shall immediately report to the county health officer the name and address of such venereally-diseased person. (Acts 1919, No. 658, p. 909; Code 1923, § 1109; Code 1940, T. 22, § 267.)

CANCER

§ 22-13-10. Uniform examination and reporting blanks; physicians' reports.

In order to obtain uniformity of examinations throughout the state and to make statistical review and research possible, the state board of health shall furnish, through county health officers, uniform examination and reporting blanks, which blanks shall be used by physicians making examinations. These reporting forms shall include standardized questions, serially numbered, and shall be made up in pads so that a report can be conveniently made in triplicate. The forms may provide for reporting the presence of palpable lymph nodes and other related and valuable diagnostic or statistical information. The original report shall be filed with the state board of health, one copy shall be retained by the examining physician and the other copy shall be furnished to the subject. Such a report shall contain the subject's answers to the questions prescribed in the examination, and the physician's answers shall be worded in simple language so that the subject can understand what has been done, whether recommendations were made and, if so, what they are. The physician's answers shall be so worded that the report of the investigation and examination will be a definite commitment, over his signature, as to the actual extent of the investigation and examination. (Acts 1949, No. 185, p. 215, § 7.)

RADIOACTIVE MATERIALS
(Excerpt from § 22-14-1)

§ 22-14-1. Definitions.

For the purposes of this chapter, the following terms shall have the meanings respectively ascribed to them by this section:

(2) IONIZING RADIATION. Gamma rays and X rays; alpha and beta particles, high-speed electrons, neutrons, protons and other nuclear particles; but not sound or radio waves or visible, infrared or ultraviolet light.

§ 22-14-8. Records and reports.

(a) The agency shall require each person who acquires, possesses or uses a source of ionizing radiation to maintain records relating to its receipt, storage, transfer or disposal and such other records as the agency may require, subject to exemptions as may be provided by rules or regulations.

(b) The agency shall require each person who possesses or uses a source of ionizing radiation to maintain appropriate records showing the radiation exposure of all individuals for whom personnel monitoring is required by rules and regulations of the agency. Copies of these records and those required to be kept by subsection (a) of this section shall be submitted to the agency on request.

(c) The agency shall adopt reasonable regulations, compatible with those of the United States nuclear

regulatory commission, or any successor thereto, pertaining to reports of exposure of personnel. Such regulations shall require that reports of excess exposure be made to the individual exposed and to the agency and shall make provision for periodic and terminal reports to individuals for whom personnel monitoring is required.

(d) The provisions of this chapter shall not be construed to limit the kind or amount of radiation that may be intentionally applied to a person for diagnostic or therapeutic purposes by or under the direction of a licensed practitioner of the healing arts. (Acts 1963, No. 582, p. 1269, § 8.)

NOTE: The agency referred to is the State Board of Health.

CONTROLLED SUBSTANCES INVENTORIES

§ 20-2-56. Maintenance of records and inventories by registrants generally.

Persons registered to manufacture, distribute to dispense controlled substances under this article shall keep records and maintain inventories in conformance with the record keeping and inventory requirements of federal law and with any additional rules issued by the state board of medical examiners, the state board of health or the state board of pharmacy. (Acts 1971, No. 1407, p. 2378, § 306; Acts 1976, No. 699, p. 965, § 4.)

(Excerpt from U.S. Dept. of Justice Drug Enforcement Administration PHARMACIST'S MANUAL)

The Controlled Substances Act (P.L. 91-513) requires each registrant to make a complete and accurate record of all stocks of controlled substances on hand every two years. The biennial inventory date of May 1, may be changed by the registrant to fit his regular general physical inventory date, if any, so long as the date is not more than six (6) months from the biennial date that would otherwise apply. The actual taking of the inventory should not vary more than four (4) days from the biennial inventory date. A registrant desiring to change the date of his biennial inventory date must notify in advance the Regional Director in his region of the date on which he desires to take the inventory.

The inventory record must:

1) List the name, address, and DEA registration number of the registrant.
2) Indicate the date and the time the inventory is taken, i.e., opening or close of business.
3) Be signed by the person or persons responsible for taking the inventory.
4) Be maintained at the location appearing on the registration certificate for at least two years.
5) Keep records of Schedule II drugs separate from all other controlled substances.

Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treotment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*), *H. influenzae*, ond Group A beta-hemolytic streptococci

Acute exacerbation of chronic bronchitis coused by *H. influenzae**

*Though clinicol improvement has been shown, bacteriologic cures connot be expected in oll patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and stophylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS coused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other thon urinory tract.)

NOTE: Perform cultures and susceptibility tests initially ond during treatment to monitor effectiveness of therapy and susceptibility of bacterio. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicoted in individuals with history of on ollergic reoction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of ontibiotics may promote overgrowth of nonsusceptible orgonisms. If superinfection occurs, take appropriate meosures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice ond rots at doses up to 10 times the human dose revealed no evidence of impoired fertility or harm to the fetus due to cyclacillin. There ore, however, no adequate and well-controlled studies in pregnant women. Becouse onimal reproduction studies are not alwoys predictive of human response, use this drug during pregnoncy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in humon milk. Becouse mony drugs ore, exercise caution when cyclacillin is given to o nursing woman.

Adverse Reactions Oral cyclacillin is generally well toleroted. As with other penicillins, untoward sensitivity reoctions are likely, particularly in those who previously demonstroted penicillin hypersensitivity or with history of ollergy, asthma, hay fever, or urticario. Adverse reactions reported with cyclacillin: diorrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in opproximately 1 in 60). Isoloted instonces of headache, dizziness, obdominol poin, voginitis, ond urticaria have been reported. (See WARNINGS) Other less frequent odverse reactions which moy occur and ore reported with other penicillins are onemio, thrombocytopenia, thrombocytopenic purpuro, leukopenio, neutropenia and eosinophilia. These reoctions are usuolly reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treotment at least 48 to 72 hours ofter potient becomes osymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, ot leost 10 days' treatment is recommended to guard against risk of rheumotic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinicol oppraisol is necessory during therapy and possibly for several months after. Persistent infection may require treotment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclocillin may be safely odministered to potients with reduced renal function. Due to prolonged serum half-life, potients with various degrees of renal impoirment moy require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg t.i.d. body weight > 20 kg (44 lbs) 250 mg t.i.d.
Bronchitis and Pneumonio		
Mild or Moderate Infections	250 mg q.i.d..	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Medio	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/doy t.i.d.†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/doy

*Dosage should not result in o dose higher thon thot for adults.
†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg ond 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

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Faster peak. Fewer problems.

. . . in infants and children

Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).[1]

Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.[2]

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.[2]

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.

*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

1. Ginsburg CM, McCracken GH Jr, Zweighaft TC, Clahsen JC: Comparative pharmacokinetics of cyclacillin and amoxicillin in infants and children. *Antimicrob Ag Chemother* 19:1086-1088 (June) 1981.

2. Multicenter trials. Data to be published.

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See important information on

Wyeth Laboratories
Philadelphia, Pa 19101

When taking the inventory of Schedule II controlled substances, an exact count or measure must be made. When taking the inventory of Schedules III, IV, and V controlled substances, an estimated count may be made unless the container holds more than 1,000 dosage units, in which case an exact count must be made if the container has been opened.

Newly Controlled Substances — occasionally a drug that has not been previously controlled will be placed in one of the drug schedules or a controlled substance will be moved into a higher or lower schedule. In either of the cases, the drug must be inventoried as of the effective date of transfer, and this inventory should be added to the biennial inventory dated June 1980.

MALPRACTICE JUDGMENTS

§ 34-24-56. Report of malpractice judgments and settlements — Filing.

Every physician or surgeon who holds a license, certificate or other similar authority issued under the provisions of this article shall, during the first 30 days of each calendar year, report to the state board of medical examiners any final judgment rendered against such physician or surgeon during the preceding year, or any settlement in or out of court during the preceding year, resulting from a claim or action for damages for personal injuries caused by an error, omission or negligence in the performance of his professional services, or in the performance of his professional services without consent. (Acts 1971, No. 2321, p. 3744, § 1.)

VIOLATIONS OF MEDICAL PRACTICE ACT (Excerpt from § 34-24-361)

§ 34-24-361. Investigations; reporting offenses; formal interview; procedure for hearings; temporary suspension; voluntary restrictions; actions to be taken by commission.

(b) Any physician or osteopath holding a certificate of qualification to practice medicine or osteopathy in the state of Alabama shall and is hereby required to, and any other person may, report to the board or the commission any information such physician, osteopath or other person may have which appears to show that any physician or osteopath holding a certificate of qualification to practice medicine or osteopathy in the state of Alabama may be guilty of any of the acts, offenses or conditions set out in section 34-24-360, and any physician, osteopath or other person who in good faith makes such a report to the board or to the commission shall not be liable to any person for any statement or opinion made in such report.

PROFESSIONAL CORPORATIONS

§ 10-4-226. Filing of initial notice with regulating board; fee therefor.

Each corporation incorporated under this article shall immediately file notice with the regulating board in writing, and such notice shall contain the name and address of the corporation and the name and home address of each incorporator and shareholder of the corporation licensed to practice such profession in Alabama. A fee of $25.00 shall be paid the board with each initial notice. (Acts 1971, 3rd Ex. Sess., No. 260, p. 4524, § 8.)

§ 10-4-230. Annual statements; fees therefor.

(a) Each professional corporation shall file with the regulating board on or before January 30 of each year a statement disclosing the name of the professional corporation and the name and home address of each shareholder of the corporation licensed to practice such profession in Alabama. A fee of $10.00 shall be paid the board with each annual notice.

(b) A professional corporation shall, within 30 days after June 30 in each year, furnish a statement to the secretary of state showing the names and post office addresses of all shareholders in such corporation and shall certify that all shareholders are duly licensed or otherwise legally authorized to practice their profession in this state. The report shall be made on such form as shall be prescribed and furnished by the secretary of state, shall be signed by the president or vice-president and the secretary or an assistant secretary of the corporation and acknowledged and sworn to before a notary public by the persons signing the report, shall be filed in the office of the secretary of state and may be accompanied or included with the regular annual report of such corporation required by chapter 2 of this title. (Acts 1971, 3rd Ex. Sess., No. 260, p. 4524, §§ 9, 19.)

NOTE: The regulating board for physicians is the State Board of Medical Examiners.

CHANGE OF ADDRESS

§ 34-24-338. Same — Contents; change of address.

Upon due application therefor, by a licensee of the medical licensure commission, and upon the payment of fees required to be paid by this article, the commission shall issue to such applicant a certificate of registration signed by the executive officer of the commission, which certificate shall recite that such person is duly registered for the year specified.

Such certificate of registration shall contain the name of the person to whom it is issued, the address of the person, the date and number of the license and such other information as the commission shall deem advisable.

If any registrant shall change his address during the year for which any certificate of registration shall have been issued by the commission, such registrant shall, within 15 days thereafter, notify the commission of such change, whereupon the commission shall issue to such registrant without additional fee, a duplicate reg-

istration certificate for such new location. (Acts 1981, No. 81-218, § 13.)

NOTE: Reference to Commission is to the Medical Licensure Commission.

PKU TESTING

§ 22-20-3. Testing infants for phenylketonuria; rules and regulations for treatment thereof.

(a) It shall be the duty of the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, or the physician attending a newborn child or the person attending a newborn child that was not attended by a physician to cause to have administered to every such infant or child in his care a reliable test for phenylketonuria (PKU), such as the Guthrie test, or any other test considered equally reliable by the state board of health. Testing and the recording of the results of such tests shall be performed at such times and in such manner as may be prescribed by the state board of health; provided, that no such test shall be given to any child whose parents object thereto on the grounds that such tests conflict with their religious tenets and practices.

(b) The state board of health shall promulgate such rules and regulations as it considers necessary to provide for the care and treatment of those newborn infants whose tests are determined positive, including, but not limited to, advising dietary treatment for such infants. The state board of health shall promulgate any other rules and regulations necessary to effectuate the provisions of this section. (Acts 1965, No. 885, p. 1664.)

PHYSICIAN DISCIPLINARY ACTION

§ 34-24-59. Reporting physician disciplinary action.

(a) The chief administrative officer of each hospital shall report to the Alabama state board of medical examiners any disciplinary action taken concerning any physician when such action is related to professional ethics, medical incompetence, moral turpitude, or drug or alcohol abuse. Disciplinary action shall include termination, reduction or resignation of hospital privileges for any of the above reasons. The report shall be in writing and be made within 60 days of the date of the action.

(b) Any professional society within this state comprised primarily of physicians, which takes formal disciplinary action against a member shall report said action to the Alabama state board of medical examiners, when the action taken is related to professional ethics, medical incompetence, moral turpitude, drug or alcohol abuse. This report shall be in writing and made within 60 days of the action.

(c) Any report made pursuant to this section shall be privileged from discovery and the individual making the report shall be immune from liability. (Acts 1981, No. 81-685.) ⊡

Are the results of
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worth reading about?

Dr. James Monroe Mason, Jr.* and His Era in Medicine†

John L. Carmichael, M.D.‡

In June, 1928, when I had been practicing medicine in Birmingham for two or three years, I attended a patient so severely injured in a street car accident that hospitalization was necessary. The patient indicated that she wanted to be admitted to the St. Vincent's Hospital where most of the injured of the Birmingham street railway system were treated when hospitalization was necessary.

In my naiveté, I called St. Vincent's Hospital and requested a bed for my patient not realizing that such a requirement as prior appointment to the hospital staff might be expected of one making such a request. However, after some hesitation on the part of the hospital, my request was granted. During the treatment of this patient, it was my privilege for the first time to meet Dr. James Monroe Mason, Jr. He was chief surgeon of the Birmingham Street Railway System.

He was then a man nearing 60 years of age, serious, gruff, and somewhat austere but above all obviously a man dedicated to the best interest of the patient and moreover, careful of the rights of a fellow physician. It was also in this first contact with him that I learned of his devotion to the Art and Science of Medicine.

Deep Roots

Dr. Mason was a member of one of Alabama's old and prominent families. He was born on November 21, 1871 in Marion, Alabama. His childhood was spent in various Methodist parsonages in Alabama as his father was a member of the Alabama Conference of the Methodist Episcopal Church, South.

His early education was obtained at the Alabama Polytechnic Institute (Auburn) and at Southern University in Greensboro, Alabama (now Birmingham Southern College). In 1894, he entered the Medical School of Alabama at Mobile and transferred after the first session to the School of Medicine, Tulane University where he received a degree of Doctor of Medicine in 1899. From 1897 to 1899, he was a resident in Charity Hospital of Louisiana at New Orleans.[1] Among his memorabilia,[2] is a certificate dated April, 1898 designating him as ambulance surgeon and apparently conferring some distinction on him.

He began his practice of medicine in Birmingham in 1899. He was an early or charter member of the surgical staffs of the St. Vincent's and Children's Hospital. He records that he performed his first operation at the Hillman Hospital in 1900. (See his response at the dinner given in honor of him on his retirement from the surgical staff in 1941.)[3] He had been greatly inspired by his Professors of Surgery at Tulane. Foremost among these was Dr. Rudolph Matas, a leader in the development of vascular surgery in the South and in the world. Thus inspired, Dr. Mason developed a keen interest in vascular surgery and became the foremost vascular surgeon in Alabama.

Travels Abroad

We quote again from his memoirs.[4] "Over the years, he kept pace with surgical progress by attend-

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* First head Department of Surgery School of Medicine U.A.B. (1945-1949).
† Read before a Physicians' Study Group and Guest, January 23, 1982.
‡ Clinical Professor Surgery School of Medicine U.A.B.

ing the outstanding clinics in this country and abroad. In 1910, 1911, and 1928, he spent considerable time visiting the foremost clinics of Europe. Again in 1938, he returned to Europe to attend the meeting of the International Society of Surgeons in Brussels when Dr. Matas was president. He presented a paper on lobectomy at this meeting.''

To better understand Dr. Mason's development as a surgeon and as a leader of medicine in Birmingham, one needs to take a backward view of medical practice in Birmingham in the early decades of the 20th century. When Dr. Mason came to Birmingham to practice medicine in 1899, he was 28 years of age and this was also the 28th year of the existence of Birmingham as a city. The founding of Birmingham occurred in the same year as Dr. Mason's birth, i.e. 1871.

A group of concerned citizens in the early 1880's had recognized the need for a charity hospital in Birmingham. ''In January, 1884, a group of public spirited ladies from Elyton met at the First Methodist Church South to organize the United Daughters of Charity.''[5] ''On March 9, 1887, the Hospital of United Charity was formally incorporated. Among the actions of the organizing committee was the decision to locate a charity hospital in or near Birmingham. . . . October 23, 1888, the first charity hospital in Birmingham opened its doors to needy patients.''[6]

This was on Twentieth Street between Avenues A and B. Later, (November, 1890) a building was erected at Smithfield (present day Graymont). This building burned in 1894 and charity wards were then opened at the corner of Twenty-First Street and First Avenue South.[7] ''On February 11, 1897, the Alabama Legislature officially chartered Hillman Hospital of Birmingham.''[8] The hospital had been named in honor of Thomas Tennessee Hillman. In 1898, Mr. Hillman gave to the Board of Lady Managers, certificates of stock valued at $20,000.[9] The Board created the Hillman Council (composed of 25 business leaders) and they purchased a lot on the corner of Fourth Avenue and Nineteenth Street South. This lot was sold however in 1902 and lots purchased at the corner of Twentieth Street and Avenue F South. Ground breaking ceremonies were held here on May 2, 1902 and the building was finished by April, 1903.[10] This building still stands (1982) at the Southwest Corner of Twentieth Street and Avenue F (6th Avenue South).

First Suggestion

In the early spring of 1898, three or four years after the burning of the United Charities Hospital at Smith-

In 1977, when
the Veterans Administration
compared Step-2
regimens in 450 mild
hypertensive patients,
which regimen was
proven most effective?[1]

field in 1894 and before the Hillman Hospital was built under the auspices of the Lady Board of Managers, successors to the Daughters of the United Charities in 1902-1903, the Reverend Patrick A. O'Reilly of St. Paul's Church of Birmingham "suggested the necessity of establishing a Hospital for the relief of the suffering poor and indigent within the confines and more particularly within the corporate limits of the City of Birmingham."[11]

Accordingly, a meeting in the Temperance Hall of the Church was called for the citizens of the community on June 8, 1898. This was well attended. A committee on organization was appointed and "instructed to report back at the next meeting, June 10, 1898."[12] The name chosen for the organization was "The Sisters of Charity Association." An organizational structure was adopted and committees appointed.

At this meeting, subscriptions of $1040.00 were raised. Weekly meetings were held and Rev. P. A. O'Reilly reported on September 8, 1898 that a ten acre site for a hospital building had been selected on Fountain Heights "and that a lease had been affected with Mr. H. F. DeBardelaben for the use of his late residence on the corner of 15th Street and Avenue B in Birmingham, Alabama as a temporary hospital until such time as permanent quarters and new buildings could be erected."[13]

On December 28, 1898, the "doors of St. Vincent's were thrown open for inspection and reception of patients."[14] One or two patients had been treated at the hospital as early as November, 1898. This was of course in the old DeBardelaben home.

"On January 20, 1899, Mother Mariana Superior of Sisters of Charity from Emmettsburg, State of Maryland paid a visit to Birmingham, Alabama and shortly after this time, the place of location for the hospital building was changed from the original site on Fountain Heights to that of 27th Street and Avenue I, the present site where on the 12th of March, 1899 . . . amidst a great concourse of people, of all creeds and denominations, with due ceremony and solemnity, dirt was broken for the erection of St. Vincent's Hospital."[15]

Children's Hospital

Another of the early Birmingham Hospitals where Dr. Mason contributed his services was the Children's Hospital. This was founded in 1911 to take care of the pediatric medical and surgical problems of the community.

Dr. Mason was an early or charter member of the surgical staffs of these three hospitals. He was later Senior Surgical Consultant of the Employees Hospital T.C.I. & R.R. Co. (now Lloyd Noland Hospital) when this hospital was founded.

During the early decades of this century, there were many private hospitals in Birmingham. Almost all if not all of these hospitals were owned by surgeons and were oriented toward the care of surgical patients. Although there were exceptions, many of these hospitals gave substandard surgical care. Some of these have succeeded and have served the public well but many failed. I can recall at least five that folded up and left somewhat unsavory reputations behind them.

One surgeon who owned one of these hospitals is reported to have said, "When a doctor sends me a patient to be operated on, I am going to operate on him regardless. I am going to protect my doctor."

In this unhealthy atmosphere, Dr. Mason stood out prominently as one among the leaders of those who seeking high personal attainment of surgical knowledge and skills was equally dedicated to using these talents for the welfare of his patients. He continued to be a student throughout his long life as indicated by frequent attendance at medical meetings and his acquaintance with medical literature. He not only gave his services to the care of the indigent, he taught interns and residents on his private and charity services.

He was a guide and teacher to the visiting staff at the hospitals where he practiced. He organized the surgical section of the intern and resident staffs of the Hillman Hospital which he headed and made Sunday morning clinical rounds with these staffs and with those of the visiting staffs who wished to attend. These were popular with both the house and visiting staffs. Dr. Mason continued these clinical conferences until he retired as active head of the surgical services of the Hillman Hospital in 1941 at the age of seventy years.

Prolific Writer

Dr. Mason was not only a teacher at the clinic and at the bedside, but he contributed also to the knowledge of surgery through his writings. I have in my file the titles of fifty-six contributions to the medical literature published in a period from 1906 to 1951. These contributions covered a wide variety of surgical problems especially those problems in the field of vascular surgery. I quote Dr. Donald C. Balfour of the Mayo Clinic: "The contributions of Dr. Mason to the surgical advances of this century were based on a wide experience in general surgery. His publications were recognized as authoritative, conservative and dependable. In the fields of trauma and infections, he added materially in the establishment of sound principle in management of such conditions as arteriovenous fistula, vascular injuries, empyema, et cetera."[16] The third to last of those contributions is a case report entitled "Spontaneous Pneumoperitoneum without Peritonitis or Demonstrable Cause." This appeared in the Southern Medical Journal on June, 1946. The last two of his writings that I found recorded in the index medicus, the catalogue of medical literature, were his memoirs of Dr. Samuel Ledbetter in the *Annals of Surgery,* January, 1947 and of Dr. William Mudd Jordan in the *Transactions of the Southern Surgical Association* in 1951.

I have found in Dr. Mason's memorabilia at the Reynold's Library manuscripts of several surgical papers that were probably read before local surgical associations and not published in medical journals.

Army Service

All of Dr. Mason's career in the practice of surgery was confined to Birmingham, Alabama, except that during the first World War, when he was on active duty in the military service. Dr. Mason served with distinction in World War I and was a Major in the Medical Corp of United States Army. He was chief of the surgical services at General Hospital Twenty-Six at Des Moines, Iowa. Here, he became interested in the treatment of empyema since this was designated the active center for treatment of empyema. On retirement, he obtained the rank of Colonel and continued in retirement to serve his country in an advisory capacity in military service.

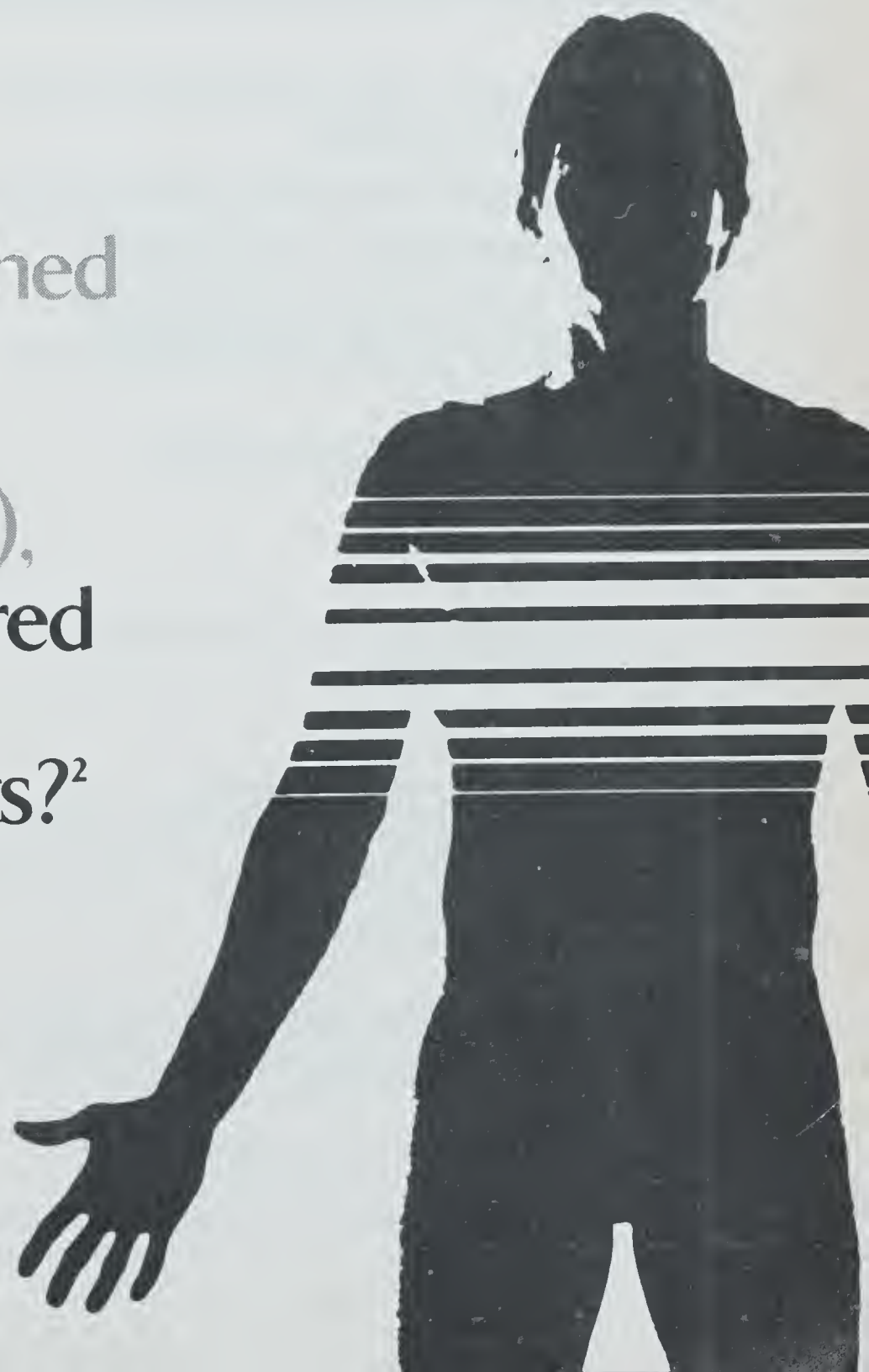
Dr. Mason, in his long and busy life, took time to help in furthering the goals of organized medicine. He was President of the Jefferson County Medical Society in 1914, President of the Alabama State Medical Association in 1942, President of the Birmingham Surgical Society in 1918, and President of the Southern Surgical Association in 1930. He was vice-president of the American Surgical Association in 1936. He was in the founders group of the American College of Surgeons and member of its Board of Governors and of its Board of Regents and of the Advisory Council of the Board of Regents. He belonged to the International Society of Surgeons. He was Chairman of the Section on Surgery of the Southern Medical Association in 1935. In 1940 as Senior Fellow of Southeastern Surgical Congress, he gave the C. Jeff Miller Memorial Lecture. In 1935 he was awarded the Doctor of Science Degree by Tulane University on the 100th anniversary of the establishment of the School of Medicine. He was a member and founder of the Alabama Society of Medical History and President in 1949-50.

He took responsibility in the general affairs of the community. He was a Trustee of the Highland Methodist Church. He was also a member of the Birmingham Country Club.[17]

Four-Year School

In Dr. Mason's Presidential address before the Alabama State Medical Association, he states: ''I feel it incumbent upon me to bring to your attention again the question of a four-year-medical school and to urge the Association to bring to bear its great influence in obtaining it. . . . ''The Alabama Citizens Committee has been greatly interested in the establishment of a four year medical school. . . . I recommend that the Association authorize the appointment by the President of a committee to cooperate with the Alabama Citizens

In 1979, when results were published for the five-year, 10,000-patient Hypertension Detection and Follow-up Program (HDFP study), which Step-2 regimen was preferred and was deemed effective without significant adverse effects?[2]



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Committee in conducting this survey and in working for the establishment of a four year medical school.''[18]

In 1941, Dr. Mason, as indicated above retired as Chief of the Surgical Staff Division A of the Hillman Hospital and was made Emeritus Chief of Staff. The visiting and house surgical staffs wanted to show their appreciation for the contributions Dr. Mason had made toward their training in Surgical care and techniques. It was decided to give a dinner in honor of Dr. Mason to be attended not only by his current visiting and house staffs but also by members of the house staffs of years past and by some of his older local surgical and medical colleagues. Also invited was Dr. Rudolph Matas of New Orleans, Dr. Mason's Professor of Surgery at Tulane Medical School during the last four years of the last century. Dr. Matas was now 81 years of age. The dinner was held at the Country Club in Birmingham, Alabama. Dr. George Graham, Pathologist at Hillman Hospital and elsewhere was Toastmaster. Besides the members of the visiting and house staffs, the following guests were present:

Dr. Henry Carter, Physician in Chief, Division B
Dr. J. W. MacQueen, Director, Hillman Hospital
Dr. Lloyd Noland, Chief Surgeon Employees Hospital, Fairfield
Dr. W. F. Scott, Chief of Urological Service, Hillman Hospital
Miss Annice Jackson, Superintendent of Nurses, Hillman Hospital
Drs. J. P. Collier, Tuscaloosa, Harold Rogers, Albertsville, Thomas Boozer, Anniston, AL, former residents on Dr. Mason's staff
Mrs. George S. Graham, (Dr. Sara McCarty Graham)
Mrs. J. M. Mason and Mrs. Augusta Mason Oden, wife and daughter respectively, of the Dr. Mason.
The staff members of Surgical Division A, Hillman Hospital

Dr. J. M. Donald spoke for the visiting staffs and Dr. J. P. Collier for the present and former house staffs. Copies of these speeches are among Dr. Mason's memorabilia in the Reynold's Library. Other speeches of local visitors were apparently not reduced to writing.

Warmth of Friendship

Dr. Matas was not able to attend but sent as his representative, Dr. Lucian Landry to read the address which he had written. Space will permit only a few quotations from this address which is redolent with the warmth of a friendship which started out in a teacher-student relationship, matured into a deep appreciation of each other and a deep affection for each other as they labored in the same field of medicine for the benefit of humanity. Dr. Matas writes: ''It was there as an interne he developed the same characteristics of studiousness, earnestness, modest and retiring unobtrusiveness, sim-

plicity, with dignity and a conscientious appreciation of responsibility, loyalty to his friends and his Alma Mater which have distinguished him ever since.''[19]

Again I quote Dr. Matas: ''In the field of vascular surgery and aneurysmology alone, in this great specialty in which we share a common interest, he stands foremost in his own state, and in the front ranks of surgery anywhere.

''In his pioneer contributions to the surgery of penetrating abdominal wounds, his original suggestions and insistence on the value of blood transfusion has marked an epoch of the greatest importance in reducing the mortality of these formidable injuries.''[20]

Again I quote: ''For he has done much to exalt the merit of our founders, much to adorn the history of his Alma Mater by his own achievements, and yet with a modesty which has hidden him in the penumbra of the great institution which he has brought to view in the sunlit splendor of his own filial devotion. Yes, filial devotion, for James Monroe Mason is, has been and will ever be, one of Tulane's ablest, most loyal and best loved sons.

''Personally, I am moved by emotion when I recall the numerous occasions on which, despite the hardship and expense of long journeys, he has come expressly from his home in Birmingham to give me the stimulus of his friendship, the encouragement of his praise, and the strength of his ever willing cooperation in all just causes or enterprises that might redound to the benefit of our Alma Mater, the profession of Louisiana and the people of the South. In witness thereof, I need simply appeal to the memories of my own 70th birthday celebration and presentation of my testimonial book in New Orleans; to his presentation of the golden cup of the American delegation at the International Congress of Surgery in Brussels; his delightful address at the recent banquet of the Clinical Congress of the American College of Surgeons in New Orleans; and his very charming speech at the Mosby dinner in St. Louis in connection with the American Surgical Association and in addition his Chaille Oration and many contributions to our annual home-coming post-graduate assemblies in which I have enjoyed his good humor and fine memory of agreeable events as well as the graciousness of his praise which might not have always been deserved but has been always gratefully received coming from him whose friendship and sincerity no one can question.''[21]

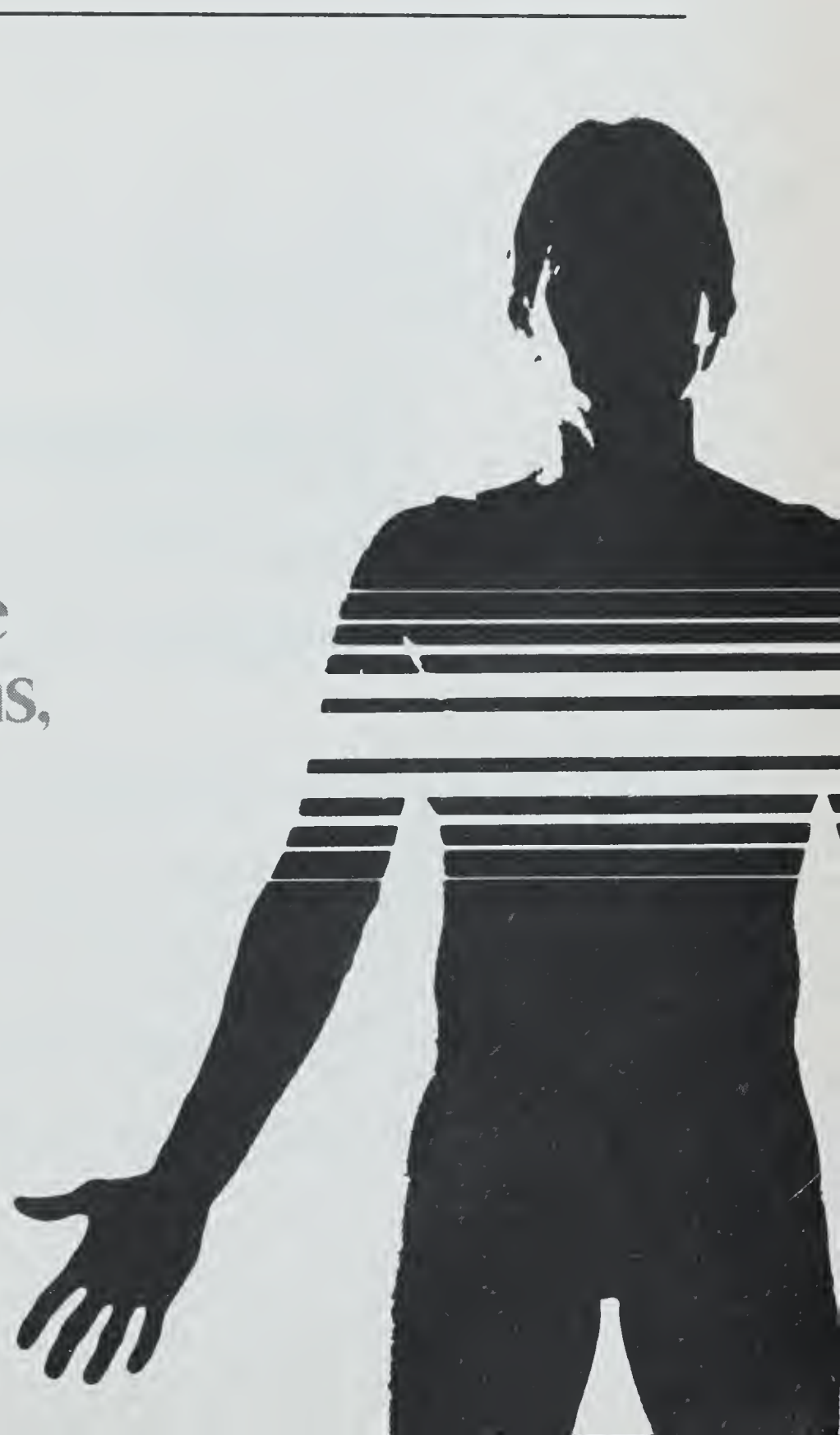
Appropriate Response

Dr. Mason's response was in words warm and appropriate. I quote two paragraphs from his response.

''Mr. Toastmaster, Guests and Colleagues:

''I cannot find words to express my appreciation of your kindness in so signally honoring me this evening.

In 1980, when the
Joint National Committee
on Detection, Evaluation, and
Treatment of High Blood Pressure
published their recommendations,
which Step-2 regimen best met
their criteria for effectiveness,
safety, simplicity of titration,
convenience, and economy?[3]



"To be surrounded by friends, some of long standing and all of intimate association, and to listen to your words of commendations is a distinction not often attained. I wish that your laudatory expressions were as much deserved as they are appreciated."[22]

Although Dr. Mason retired from his Hillman service, he did not retire from surgical practice. He kept his office open. The Second World War began December 1941. He "was Surgical Consultant for Selective Service in Alabama; Chairman of Fourth Corp Area War-time Graduate Medical Meetings at hospitals in Alabama and Mississippi and a member of the joint committee of the A.M.A., American College of Surgeons and the American College of Physicians for Coordination of Medical Activities."[23]

Emeritus Status

In 1945, a further duty came to Dr. Mason. The medical school was moved to Birmingham from Tuscaloosa and reorganized into a four year Medical School. He was the logical surgeon for head of the Department of Surgery, although he was now 76 years of age. He agreed to serve until a younger suitable Professor of Surgery could be found. He, with Dr. Robert Guthrie, a former resident on his Hillman Hospital staff, as Executive Officer ran the Department of Surgery until 1949 when Dr. Champ Lyons came as full-time Professor of Surgery. At this time, Dr. Mason was named Professor of Surgery Emeritus.

One of the last honors to come to Dr. Mason was the presentation by his friends of his portrait to the Medical College of Alabama. We quote Dr. Joe Donald in his memoirs. "It was indeed an impressive ceremony; his many friends came from near and far for the unveiling; the auditorium was full to overflowing. Speakers for the occasion included Dr. D. C. Donald, Chairman of the Portrait Committee and Dr. Alton Ochner, the late Dean Dr. Roy R. Kracke; Dr. J. M. Gallalee, President of the University of Alabama. Dr. Rudolph Matas being unable to attend wrote a beautiful tribute to Dr. Mason which was read.

"Dr. Mason's response exemplified the character of this great man. He stated, 'This occasion causes me to realize that I have attained the three objectives of my life. (1) To bring up my family in such a manner that they will be a credit to the community in which they live. (2) To so conduct myself that I will always be surrounded by loyal friends. (3) To contribute something to medical education and to advance the Science of Surgery.' "[24]

In 1901, Dr. Mason was married to Grace Hardie Lovelace of Marion, Alabama. They have been blessed by three fine children, Augusta Fitzgerald (Mrs. J. R. Oden); the late Dr. James Monroe Mason, III and

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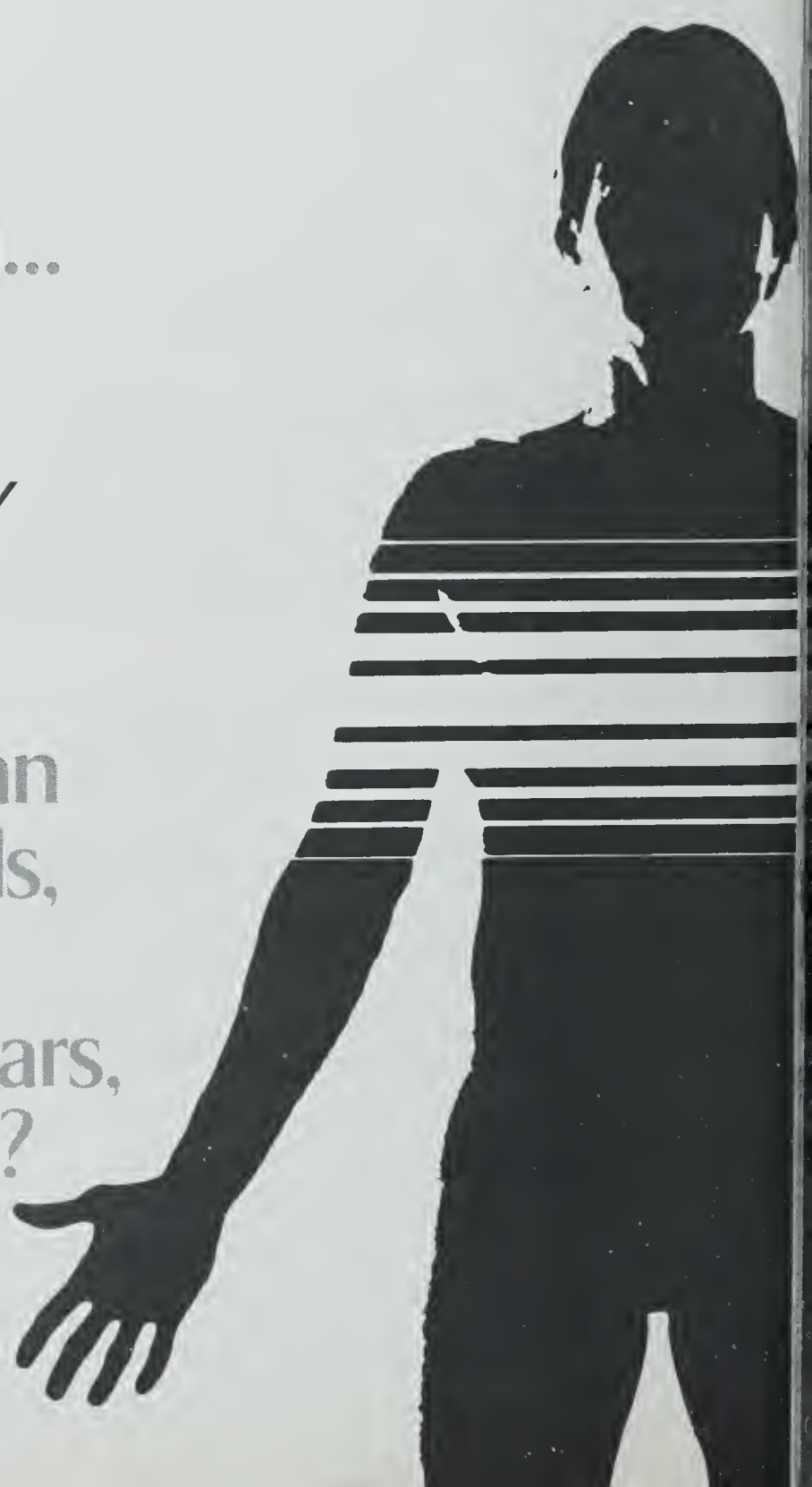

Virginia Grace (Mrs. E. B. Glenn) and six grandchildren. Dr. James Monroe Mason, III was following in his father's footsteps until his untimely death. The medical literature contains a number of surgical contributions under his authorship.

One of Dr. Mason's last civic accomplishments was the removal of the statue of Dr. W. E. B. Davis, Founder of the Southern Surgical Association, from Woodrow Wilson Park to the grounds of the Medical Center.[25]

Despite the many activities depicted above, and the active private surgical practice, Dr. Mason served for many years as Chief Surgeon of the Birmingham Electric Company.

Personal Debt

In this discussion of Dr. Mason's life and career, I would be remiss if I did not acknowledge my very great personal indebtedness to him for guidance and assistance in my surgical training and for his generous sponsorship which resulted in my attaining membership in the American College of Surgeons and also certification by the American Board of Surgery.

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Liberal Arts in Pre-Medical Education

Jeffrey H. Cohn, M.D.*

Because of my role as a practicing physician and as a clinical teacher in this medical school, I have contact with senior medical students, residents and, of course, other practicing physicians.

These people with whom I have contact are what might be classified as the finished products of the medical education pipeline. This pipeline starts before Medical School — it starts in Undergraduate School.

Those of you who teach undergraduates have the opportunity to encourage pre-medical students to study subjects which might result in a broad based liberal arts education rather than one that is intensively scientific. But today there is a trend among Medical School applicants away from the humanities and towards the sciences. Over the past 10 years, as competition for admission to medical school has increased, undergraduates have taken many more science courses and fewer courses in history, philosophy, literature, and the social sciences.[1]

During that same decade another seemingly contradictory phenomenon has occurred: American medicine has come under attack. Two of the most painful criticisms that we hear are that doctors are a narrow-minded, technically trained bunch who should no longer be thought of as members of the society of learned people. The other criticism is that American physicians are not compassionate.[2] One cannot help but wonder if a more liberal undergraduate education might begin to restore medicine to its previous position.

Only four science courses are required in the undergraduate's medical education for admission to Medical School. These are: Physics, Biology, Inorganic Chemistry, and Organic Chemistry. The admission brochures encourage Medical School applicants to major in subjects outside of the sciences but very few of them do. Many pre-medical students take extra courses in Science and eventually declare majors in the Natural Sciences because they think that their chances of obtaining Medical School admission are increased by doing this and they think that the undergraduate science courses will improve their performance in Medical School.

However, these notions may not be true. In 1977, Historian Oscar Hanlin wrote to some of his former students who had become physicians, and expressed the fear that many of Harvard's undergraduates were sacrificing a well-rounded education for the single-minded pursuit of medical school admission. He also was concerned that this was undermining the college's liberal arts mandate and affecting the non-pre-medical students as well.[3]

Within the past 18 months three articles have appeared in the *Journal of the American Medical Association* which addressed the issue of pre-medical education. Some interesting data has been published. In 1978, only 12% of all medical school applicants had pursued a non-science undergraduate major.[3] However, if one looks at the acceptance rate of these liberal arts students, one finds that there was no significant difference in the chances of getting into medical school if one was a science major or a non-science major.[1, 3]

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* Dr. Cohn, Birmingham urologist, prepared these remarks for part of a panel discussion in Birmingham on the uses of the humanities, sponsored by the Alabama Historical Association. Dr. Cohn's undergraduate degree at Virginia, where he made Phi Beta Kappa, was in Economics.

The chances are still about 50% that any applicant will obtain admission to some Medical School although it may not be his/her first choice. The chance of getting into the first choice school is approximately one in five. If one looks at admission chances by particular major subject, the Bio-Chemistry major is the most likely to be accepted. He has a 59% chance of admission. However, 58% of all Music majors were accepted in 1978. The acceptance rate for Chemistry majors was the same as the acceptance rate for Economics majors at 53%.[3]

Now that this question is resolved, the anxious undergraduate might question how well he would perform on the Science part of the medical college admission test. Studies have shown that non-Science majors perform as well as Science majors.[1, 3] This is explained by knowing from where the questions on the Science portion of this test are taken. They are taken from the four introductory Science courses that medical schools require and the questions do not come from the advanced courses.[3]

What about the performance of students after they get into medical school? Well, liberal arts majors have a more difficult first year but after that their ultimate class standing, their residency selection and their performance on the National Board of Medicine exam is no different from Science majors.[1] Of course, the real question is whether having a liberal arts undergraduate education makes one a more compassionate physician who makes better clinical judgements. To date, no studies have been designed to measure these qualities and so the answer to that question is not known.[4]

Society expects physicians to be absolutely technically competent and no one would suggest that liberal arts should be studied if that study would detract from one's ability to be a technically competent physician. The technical expertise in medicine is gained during Medical School and residency training. Very little, if any, of the technical aspects of medicine are learned during undergraduate school. The purpose of the Science courses in undergraduate school is to teach students the language through which the scientific aspects of medicine can be learned during the Medical School years.

Thus, one might suspect if pre-medical students were not pressured by their anxieties to take Science, they might elect more liberal arts undergraduate education. In describing Sir William Osler, Edmund Pelligrino has said that the ideal physician combines superb clinical talents, scientific perspective, and human concerns with the skills that have been traditionally identified with a liberal education. That is, the ability to think and to write and speak with clarity and moral sensitivity. These capacities have traditionally been taught by formal study of the disciplines of language, literature, philosophy, and history.[2]

The study of history can be a laboratory in which the physician can gain insight into how previous societies approached social issues that may be confronting current society. For example: Would physicians approach the subject of euthanasia with less fear and frustration if we were more familiar with the differences between the views of Socrates and the views of Hippocrates?

Thus it seems that the modern physician must first be fiercely competent in the technical aspects of his trade. But the technical expertise is gained after entrance to Medical School. The undergraduate years might best be used to develop communication and thinking skills. In the words of Lewis Thomas, who is a best-selling author and President of Sloan-Kettering Memorial Cancer Center in New York:

"Society would be the ultimate beneficiary if we could look forward to a generation of doctors who have learned as much as anyone can learn in our colleges and universities about how human beings have always lived out their lives. Over the bedrock of knowledge about our civilization the medical schools could then construct as solid a structure of Medical Science as can be built, but the bedrock would always be there holding everything else upright."[5]

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Rapid Tranquilization of Disturbed Patients

John Davis, Jr., M.D.*

Severely agitated patients frequently are difficult or impossible to evaluate clinically and will not cooperate in appropriate treatment. Clinical deterioration, injury to self, or others, even death may occur if the behavior cannot be controlled, evaluation made and treatment instituted.

Rapid tranquilization techniques control or decrease disturbed behavior in many patients. The major contraindication is the presence of a space-occupying lesion.[1] Caution should be exercised where hypoglycemia, hyperglycemia or hypotension exist.[1] Severe sedative-hypnotic withdrawal states and uncontrolled hyperthyroidism necessitate cautious use of rapid tranquilization techniques.[2, 3]

I have most often used Haloperidol (Haldol), Perphenazine (Trilafon) and Trifluoperazine (Stelazine). The initial dosage of 2.5-10 mgms is given I.M. with the dosage size based upon the severity of symptoms, patient age, and apparent physical condition. The same dosage (smaller or larger if indicated) is repeated every 20-40 minutes until the patient becomes manageable. If possible, vital signs are monitored every 15 to 30 minutes during this process. Behavior usually is controlled with 10-40 mgms I.M. of the chosen neuroleptic. Patients who are resistant to initial injections of the above phenothiazines may respond well to haloperidol injections or vice-versa.

If severe disturbed behavior continues, Mesoridazine (Serentil) or Chlorpromazine (Thorazine) 12.5-25 mgms I.M. or 25-75 mgms of concentrate every 40-60 minutes may then be tried, for several doses. Profound hypotension is possible with these drugs and necessitates very close monitoring of blood pressure.

Where severe, life-endangering behavior necessitates immediate control, Haloperidol 5-10 mgms can be given slowly by intravenous route, often with rapid, effective results.[1] The I.V. route is not FDA approved for Haloperidol, but a related drug (Droperidol) is a constituent of an FDA approved anesthetic, Innovar.[1]

If hypotension occurs and a vasopressor is required, Levophed or Neo-Synephrine are recommended. Epinephrine may cause paradoxical drop in blood pressure and should be avoided.

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Psycho-Economics (or Economists Propose, But People Dispose)

Eugene Stanaland, Ph.D.*

Something New?

I may be accused of starting something here. I have been exposed to socio-economics, but I do not recall psycho-economics. The idea has generated from my attempts to practice economics as a consultant and management development trainer since leaving Auburn University in September of 1980.

I have come to the conclusion that to be an economist these days you either have to be psycho or are going to be. As someone has suggested, to be an economist in the present economic circumstance you have to be a masochist. And a masochist is a guy who takes laxatives and goes for long bus rides.

I have traveled across the country and even to Europe recently to speak to corporate management groups and have in the process heard just about all the invectives, jokes, and derisive comments that have ever been uttered about those who populate this profession: ''Economists have predicted 7 of the last 3 recessions.'' ''If you laid all the economists end to end, they wouldn't reach a conclusion.'' ''If you have five economists, you get five different opinions, and if one of them is a Harvard economist you get six.'' ''In Poland they are telling economist jokes.''

It's enough to give one an inferiority complex.

Science or Fiction?

The forecasts gone astray, the contradictory prognostications, the mystic language, and the failure of the economic models have all cast a pall of skepticism about whether economists really know what they are talking about. These concerns of validity and competence are by no means new. In the past, economics has been under question for claiming the distinction of the title Science. Albeit a Social Science, the title has been questioned by those in the so-called ''hard'' sciences — chemistry, physics, etc.

The economist, for instance, refers to the ''Law of Demand.'' Now a law in the sciences is a pretty serious designation. It refers to a relationship between substances, forces (or what have you) that is certain, constant, without exception, and can be counted on to repeat itself without fail. The law of gravity is an example. The laws of the ''science'' of economics cannot claim such properties. Even our ''Law of Demand'' works only most of the time.

There are exceptions. A textbook example is the ladies shoe store overstocked and underselling a pair of shoes priced at $3.99. When the price was increased to $7.99 they sold like hotcakes. The phenomenon is characterized as an example of conspicuous consumption or some other such explanation. Mainly though, it is just an admission that we are dealing with people, not chemicals or forces or inanimate objects.

Psycho-Economics merely suggests that we must be prepared to accept that people are not constant, not dependable in their reactions, and will do something completely unpredictable just to make a liar out of a poor struggling economist. The physicist becomes impatient with us when we plead that our ''laws'' must be accepted with ''exceptions.'' His response is ''suppose we told you that the law of gravity works **most of the time?**'' Everyone would certainly want to remain close

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to something we could grab on to when gravity decided to take a break.

In other words, the hard scientist would argue that economics is not a science and consequently cannot produce precise descriptions of our environment or predictions of what it is going to do. Economists would be a lot better off if they would admit this point rather than fighting for the distinction that the title ''science'' might bring to this area of study.

The Psychology of It All

Many of the seeming paradoxical, contradictory sounding statements by economists can be explained by the psycho-economic response of people in the economy. Even today's recession-high interest rate condition might be attributed to this phenomenon. Certainly, some of the differences of opinion about the outcome of the application of Reagonomics, or supply side economics depends on two different perceptions of the psycho-economic reactions in the market place.

They certainly produce the raw material for the surplus of jokes about economists. Unfortunately, it also results in skepticism about the profession at a time when more certainty is needed to bring a feeling of confidence and a consequent return to growth and prosperity.

The Law — Broken Again!

The Law of Supply & Demand suggests that when the supply of a good increases, relative to the demand for it, the price will drop. If that is so, why in recent months when the Federal Reserve reports that the money supply has increased, the interest rate immediately jumps up? When the figures show a decline in the supply of money, the interest rates have been going down. The Law implies the exact opposite. What is the problem? Obviously economists are responsible for the whole thing because they don't know what they are doing and they insist on getting the bucket mouth with great frequency to insure that everyone finds out about it and is thereby confused.

There may be another explanation. People who lend money, especially those who lend it for long periods of time, are concerned about the rate of inflation and the effect it has on their rate of return. If they lend $1,000 for 1 year and the inflation rate during that period of time is 10%, then the $1,000 returned at the end of the loan period is now worth only $900. In real terms, suppose men's suits cost $100 each. The money loaned at the beginning of the year was worth 10 suits. The 10% inflation increased the cost of the suit to $110, so the $1,000 returned at the end of the year is worth only 9 suits.

Before feeling too badly for the lender, remember that he receives an interest income for the loan which is supposed to pay him for foregoing the use of the money himself; the risk he takes that the borrower might not be able to pay him back; and, for the cost of doing the paper work to administer the loan. Assume that the normal rate of return to cover these items is 8%. If the lender received $80 for the use of his money during the 10% inflation period he would lose $20 on the loan. To avoid the loss due to inflation the lender will require what is called an ''inflation premium.'' In other words, he will raise the interest rate sufficiently high to cover the potential loss from rising prices.

In the example cited here he would have to set an interest rate of 18% to get his normal rate of return of 8% and an inflation premium of 10%. The inflation premium is of necessity a forecast of what the lender thinks the inflation rate will be over the period of the loan. Also, his ability to get the regular rate plus the inflation premium will depend on the money market conditions and his willingness to make money available at something less than his estimate of inflation.

Thinking Makes It So

In today's economy, people view the changes in the money supply as directly related to future inflation rates. In the past, increases in the money supply have led to increases in prices because we have added money to the economy at a faster rate than we have added things to buy.

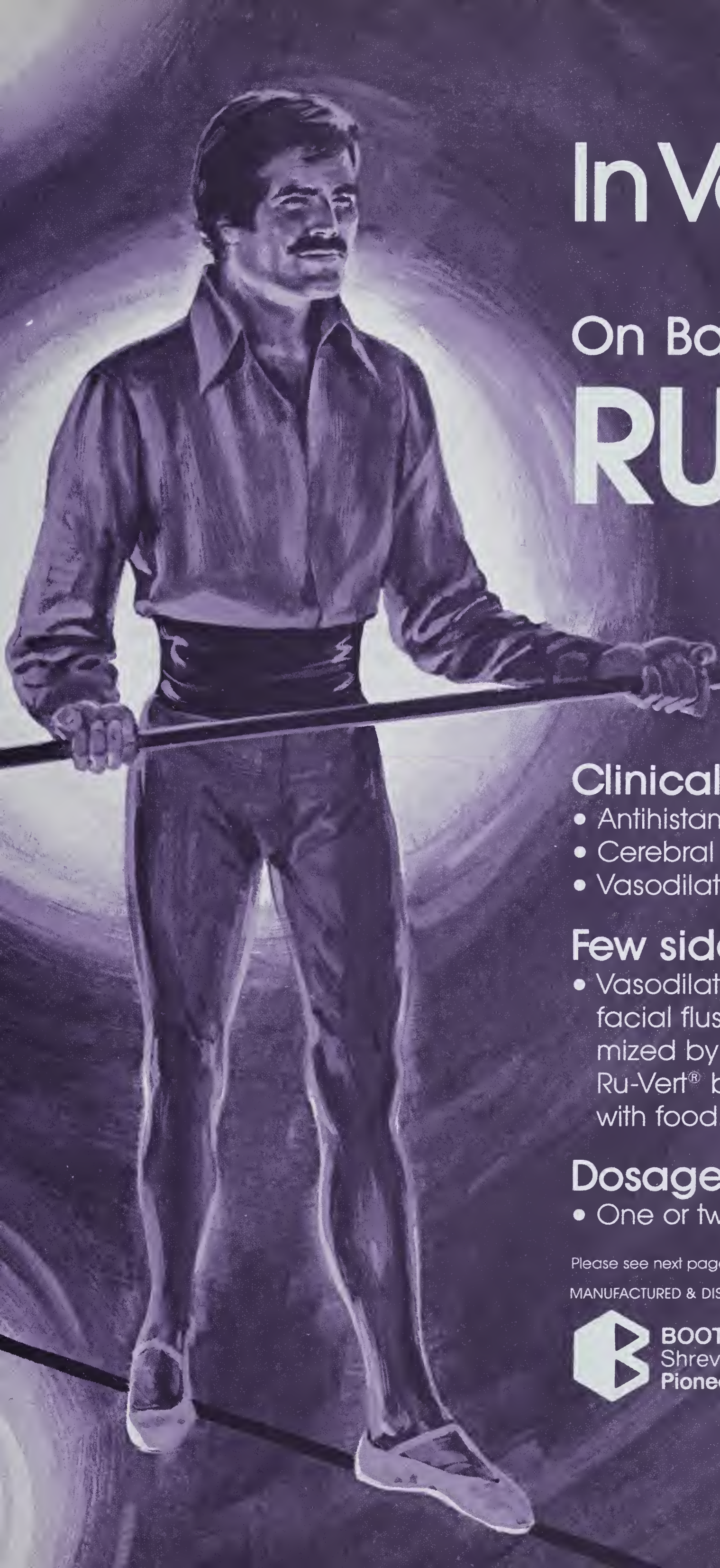
In the present condition of recession, money market people are concerned that the Federal Reserve will respond to the plight of the interest sensitive industries, such as housing and automobiles, by flooding money into the markets in an attempt to drive interest rates down. This has been the custom in past recession situations. Hence, every time the money supply figures show an increase, the interpretation is that we are returning to our old inflationary ways and the inflation premium goes up.

When the money supply figure goes down, the inflationary fears are calmed and the premium falls, bringing interest rates down. Thus, the rates are generated not by the present supply of money, but rather by what money market people **think** the Fed is going to do and what they **think** the future consequences will be — psycho-economics at its best.

Making the Forecasts Work

Have you noticed that incumbent Administrations economic forecasters seem to always be more optimistic than the remainder of the economics profession? The reason is a response to psycho-economics. If consumers, business investors, and the financial markets are convinced that the economy is going to improve, they will actually make decisions that will bring that condition about.

People who are optimistic about business conditions want to get in on it, or be ready for it when it happens so they invest in production facilities, inventories, etc. This results in employment and injections of purchas-



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ing power into the economy and helps to bring about the forecasted increase. You might say it is the patriotic duty of government officials to do all they can to solve recession situations and therefore have an obligation to be optimistic in the hope it will be contagious.

This whole process is not unlike the inflation psychology with which we are all acquainted which suggests that if everyone thinks prices will be higher tomorrow, they will get out there and buy today. Of course the increased demand today results in pressure on prices fulfilling the forecast of rising prices.

A Two-Bladed Ax

We have just seen that the anticipation of an event can help to bring it about. However, in some cases the anticipation of an economic event can prevent it from happening. The large number of doomsday economic forecasters of recent months who have made fortunes warning of and writing books about how to avoid or even profit from the coming disaster make a significant contribution to the economy by insuring that their forecasts will not come true.

In 1973, when the oil embargo hit and dire predictions were made about this country's energy crises . . . If we continued to use oil products at the rate we were going we would be out of oil by 20XX, etc. This kind of forecast brought to the attention of the population the need for conservation action along with the development and use of substitute energy sources. The results have been tremendous. Significant savings have been accomplished and more are to come, to the point that OPEC countries are concerned about their ability to ever return to the pace of increasing prices for their product that they have enjoyed in the recent past.

In this case the anticipation of an event helps to keep it from happening. If I am standing in a room and begin to walk toward a wall, after three steps I have given sufficient data to mark a trend or direction which can be used to project my course and ultimate destination. The projection can be made that if I continue the set course I will walk into the wall at the other end of the room. If I am in a position to hear the forecast, you can bet the old home place that I will probably not hit the wall.

Current Psycho-Economics

What of the current psycho-economic condition? I have recently returned from a meeting in Hawaii which brought together Chief Executive Officers from a wide variety of businesses from across the world. The meeting attracted program participants ranging from the two former Presidents Ford and Carter all the way down to yours truly. Among the presentors were an advisor to all three of the most recent Republican Presidents including the incumbent. Another speaker was a professional economist who writes a newsletter that enjoys national and international circulation.

The advisor was about as optimistic as one could be about the economic future — interest rates falling over

the next two years with inflation hitting 4%, etc. The newsletter man predicted unemployment rates of 10.5% and a prime interest rate of 20 to 25%. His advice to the CEOs at the meeting was to go home and reduce employment in their firms, cut inventories, and clean hard on those accounts receivable.

My presentation was not as optimistic as the advisor, nor as pessimistic as the newsletter man. I was right down the middle — my mama didn't raise no fools.

The interesting thing about these presentations is to study the possible psycho-economic effects of them. The Administration advisor was adhering to the belief that supply side and Reagonomics will work and was making his contribution to its success by virtue of a forecast to help make it come true. If the newsletter man was successful in getting the company presidents to follow his advice when they got back home and reduce employment, etc., he would certainly be getting a lot of help in making his forecast come true.

My forecast was of the "Safe-Chicken" variety. Both of the other people were so far from the middle at least one of them would be afraid to return to the meeting a year hence because of embarrassment. My forecast was so innocuous I will probably not be too far from whatever happens.

The Psycho-Economics from the Supply Side

One of the distinguishing features of the economic debate of recent months in our country has been the wide variance of predictions coming from the Administration's economic team and most of the rest of the forecasters in the country. This includes such things as the inflation rate, growth of real GNP, the incentive effects of the across the board tax cut, and the consequences of the changes wrought by the new beginning legislation that brought deregulation, depreciation tax changes, savings incentives, etc.

When these changes are plugged into the computerized economic models of private consulting firms, universities, et al., they spell disaster. The Administration economists reply that they are not at all surprised because the models being used describe an economic environment that doesn't exist anymore. They specifically refer to the psychological impact of a new direction that will stop inflation, create a new and more attractive environment for business and workers, all of which have not been in being before this administration and this legislation. Therefore, the predictions from the models are not valid.

How do you prove all this? You can't, because you are dealing with psycho-economics and if you can get people to believe it, it will be so. Hence, we see the importance the President has placed on not swerving or giving any hint that there is a lack of confidence that his program will not work. His credibility along with the success of the entire program hangs in the balance. This is psycho-economics at the highest level.

Which Psycho Is Right?

Who is right? Is it the Advisor, the newsletter writer, your humble Chicken, the Administration economists, or the traditional economic modelers? The last couple of years have brought such tremendous changes in the political direction of the society; changes in the structure of our financial institutions; and tax and regulation legislation that has created a new business incentive environment to which the economy has not had an opportunity to respond fully.

It is virtually impossible to say which group has the best handle on the outcome. The people out in the markets are going to make the final decision. I have found, as in the case of the Hawaiian meeting, they sit and listen to all the so-called experts, but retain their own views and feelings about economic conditions and are not swayed as much by "expert" opinion as us experts would like to think. The experts only report what the practitioners do and guess what they might do, but it is after all they who chart the course of the economy based on their thoughts and feelings, or psycho-economics.

Traveling across the country, getting exposure to a lot of top level management people in a wide variety of businesses, I am struck by the long run optimism they have for the chances of success for the Reagan programs. Even those in hard-hit industries, like construction, are complimentary of the medicine that they are being required to take in terms of the need for it in spite of its devastating effects on them personally.

I think there is sufficient positive psycho-economics abroad to give the President an outstanding chance to succeed in his quest for a new, more stable, and growing economy. ⊡

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A Practical Approach to the Diagnosis and Treatment of Diarrhea — 1982

W. Roger Carlisle, M.D.*

Diarrhea is a common problem seen by all primary care physicians. As in any disease, the essential success to the evaluation of diarrhea is beginning with a very careful history. Most diarrhea seen in my practice is never evaluated or treated. Patients are usually given some mild nausea medicine and encouraged to drink GatorAde for the first 2-3 days of their diarrheal illness. Virtually all diarrheal illnesses with the exception of Amoeba and Protazoa resolve without treatment. Diarrheal illnesses are generally treated over the phone with fluid supplementation. High fever, toxicity, dehydration, or persistent diarrhea often necessitate admission and evaluation. Ninety percent of the diarrheal illnesses commonly encountered will resolve without treatment except for fluid and electrolyte support.

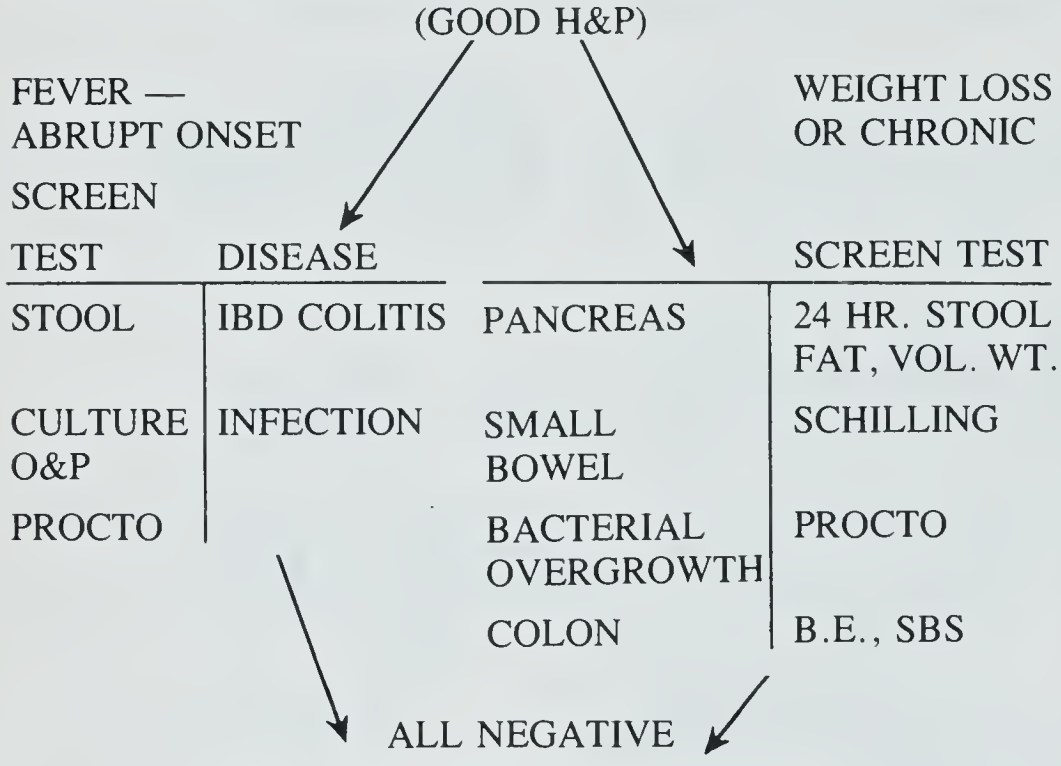
In the practical approach to diarrhea, I like to divide patients into acute febrile syndromes and chronic weight loss syndromes (Table I). Obviously, the acute febrile syndrome suggests inflammatory bowel disease or infection. In the evaluation of these diseases, evaluation is directed by the history and physical. The H&P will generally eliminate iatrogenic drug, laxative and metabolic causes of diarrhea. If these causes are not present then the evaluation for febrile causes would concentrate on the stool culture, stool examination for ova and parasites, and proctoscopy. If the history suggests chronic weight loss, or chronic symptoms, then the evaluation will initially focus on a quantitative stool for fat, volume and weight. The stool weight should be less than 250 gm. on the average American diet.

To approach diarrhea in the initial evaluation, we do simple screening tests which cover the full gamut of diarrheal diseases. The stool for culture and parasites and proctoscopic examination would generally detect infection and inflammatory bowel disease. The stool fat, weight and volume will generally detect pathological diarrhea. This test will screen for virtually all forms of malabsorption. We use the Schilling test to screen for bacterial overgrowth. If the barium enema and small bowel series are normal and the above tests are normal, then a diagnosis of irritable bowel syndrome is made by a process of exclusion (Table I). Sometimes, Level II tests are necessary i.e. small bowel biopsy, D-Xylose absorption tests, ERCP, VIP level, gastrin level and CT scan are often necessary to evaluate pancreatic, hormonal, neoplastic and small bowel causes of diarrhea.

In a recent article published in *Gastroenterology,* 1980, 27 patients were reported with suspected pancreatic colera or hormonal mediated secretory diarrhea. From this series of diarrhea of undetermined etiology, the largest groups of patients were found to have surrepticious ingestion of diarrhea causing drugs and irritable bowel syndrome. In general, most diarrheas will be found to be due to irritable bowel syndrome or gastroenteritis. Many of these patients can be successfully treated with little or no sophisticated testing. The criteria for the diagnosis of irritable bowel are shown in Table II.

* Birmingham Gastroenterology Associates, 2018 Brookwood Medical Center Drive, Suite 303, Birmingham, Alabama 35209.

TABLE I
DIARRHEA — FIVE DAYS



Approaching acute infectious diarrheas we commonly see Salmonella, Shigella, Campylobacter and Giardia infections. Travelers of course experience Enterotoxigenic E-Coli which usually will resolve spontaneously in 6-12 hours. The invasive diarrheas i.e. Shigella, Salmonella, Campylobacter, Amoeba, Colostridium Difficile, and Vibrio parahemolyticus, will cause leukocytes to appear in the stool. The most common infection causing stool leukocytes is Shigella. It is very helpful in evaluating patients with infectious diarrhea to do stool smears for leukocytes since we can separate invasive organisms from the toxin producing organisms. Enterotoxigenic E-Coli, Clostridium perfringens, Staph Aureus and B Cereus are the common organisms which cause toxin induced diarrhea. These infections are generally self-limited and will only require fluid and electrolyte support. It is important to remember that Salmonella gastroenteritis is a very benign self-limited infection of the intestine. However, Salmonella typhi or enteric fever and Salmonella bacteremia are very different and distinct syndromes which have very severe and potentially catastrophic complications. Most medical centers are reporting Campylobacter very commonly. Campylobacter is a recently recognized cause of bloody diarrhea and a colitis which mimics ulcerative colitis and regional enteritis.

TABLE II
IRRITABLE BOWEL SYNDROME

No fever or systemic symptoms
No anemia
Negative hemoccult
Normal sigmoidoscopy
Normal barium enema
No nocturnal diarrhea
Pain is relieved with defecation
24 Hour stool weight < 250 Gm
No weight loss

In evaluating patients with chronic diarrhea and suspected malabsorption, the stool weight is the most important test. Patients who have stool weights above 250 grams on a normal diet are liable to have a pathologic diarrhea. If the patient is placed on IV's and made NPO, most diarrheas will stop, unless they are secretory in origin. If the diarrheas are secretory, this often suggests a malignant syndrome or pancreatic tumor which is secreting a prostaglandin or VIP like substance which causes secretory diarrhea. In general practice, these syndromes are extremely rare and are rarely ever necessary to evaluate in most patients with diarrhea.

There is a new test which will soon be available called the BENTERIMIDE TEST. This is an oral agent which is selectively cleaved by pancreatic chymotrypsin. The chymotrypsin cleavage causes a release of Paba which is readily absorbed through the intestine and excreted in the urine. This is a new way to evaluate pancreatic exocrine function. It will revolutionize the diagnosis of maldigestion from pancreatic disease. This test will allow us to give a D-Xylose Compound and Benteramide Compound concomitantly. With a simple five hour urine collection, we will be able to evaluate the small bowel and pancreas at the same time.

In summary, a complete hospital work-up of complicated diarrhea is rarely necessary. There are usually clinical clues in the history which will indicate irritable bowel syndrome, lactose intolerance, or common self-limited infections. We do commonly see colitis, Giardia infestations, diabetic neuropathic diarrhea, bacterial overgrowth, and pancreatic insufficiency. However, the rare neoplastic syndromes of neoplastic and MEA syndromes are rarely seen.

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Executive Director

continued from page 4

The message now being broadcast from all quarters is deceptively simple: we must do the best we can with what we have. What makes that seemingly simple formula so difficult to apply is few people agree on what should have priority.

It is not necessary to look at past, present and future debates in health care policy to understand that sincere, well-meaning people can totally disagree.

Take Defense again: Do we need flocks of B-1 Bombers, Stealth Bombers and MX missiles, as some say, to the neglect of, say, the carrier Navy and nuclear submarines, or do we need all of the latter we can possibly buy and none of the former? Or do we just need a sampling of each? Good and knowledgeable men disagree, and with reason — we can only guess the future shape of Soviet intentions. But those guesses affect in a substantive way the resources we will have for other national objectives.

In health care, prioritizing may be even more painful as our legislative bodies must decide, by triaging our available resources, what is most important.

It is shaping up as a painful and traumatic period ahead in all fields of public policy, made so by a generation of reckless political promises and the rising expectations of too many Americans that the government exists only to serve their needs.

As the Government Accounting Office has pointed out, the public frequently confuses wants with needs. Now is surely the time for making that distinction clear.

President's Page

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almost solely blamed for skyrocketing medical care cost. The ways are subtle (hospital spokesmen: "We don't admit patients, doctors do"), and not so subtle (government spokesmen: "Physicians are directly responsible for 70% of medical care cost").

Unless medical leadership emerges to restructure the way we provide and pay for medical services, the consequences will prove increasingly serious in the years ahead. In a period of scarce national resources and increasing demand for medical and hospital services, rising medical care costs may threaten the stability of essential health care institutions and represent a potential threat to the health of the country, particularly the poor and the aging.

The combination of the prohibitive cost, the real physician surplus, and other forces in our society represents an immediate threat to the fee-for-service system which has made American medicine great — the system in which the physician works for the patient, who has the freedom of choice of physician and institution, and in which the physician has the freedom to treat whomever he or she wishes.

While recognizing that in a society such as ours we must have a pluralistic approach, I believe sincerely that the patient is best served when the physician works for that patient with no third party intervention.

To salvage the traditional system, physicians must be more active in assuming their responsibilities as trustees for the public interest in controlling cost and protecting the quality of care. Dr. Arnold S. Relman, editor of the *New England Journal of Medicine* and professor of medicine at Harvard Medical School, is in favor of a physician-led movement that he calls "responsible professionalism."

Such a movement would require the support of the American Medical Association as well as other specialty organizations. First and foremost, physicians should separate themselves from any secondary financial gain, so that doctors' incomes from medical care would be limited to the services they personally deliver or supervise. Just to show the public as well as other interested groups that we are credible, one of the initial steps should be an investigation into the manner in which physicians are reimbursed for their services.

I feel that the usual, reasonable, and customary profile "system" has been inflationary and has led to inequities that are unexplainable and unnecessary. In Birmingham, similarly trained surgeons are reimbursed for the same procedures in amounts varying by more than 100%.

In addition, the present system allows starting physicians to be reimbursed at a higher level than physicians with the same training and much more experience.

We must move toward the free market place. Doing so, we should advocate an indemnity system, in which the physician is reimbursed by third parties at a set amount. The indemnity system would allow the physician to charge whatever he thinks his services are worth. The patient would be expected to pay the difference between what is reimbursed by the third party (for example, Blue Shield) and the physician's actual charge.

In addition, we need to redress the imbalance between reimbursement for primary care and those for specialized procedures. There is something inherently wrong with a system which reimburses an internist who has cared for a coronary thrombosis patient for a full day only one-fourth the amount he is reimbursed for passing an endoscope. Promotion of the cognitive concept in medical care is very much needed.

Reform in hospital reimbursement is a must. Cost-plus retrospective reimbursement has proven to be an

absolute failure, promoting inefficiency in a very elaborate and expensive manner. Responsible physicians' professional groups should work with business and third party payors to find a more equitable way whether it be prospective reimbursement or some type of incentive system.

Physician and business groups working together must lead the emphasis in health care away from the horizontal inpatient concept toward the vertical outpatient concept. In order for this to be financially valid, hospitals must develop a two-tiered charge system in which the outpatient is billed only for the service that he or she receives. The outpatient's charges should not reflect capital expenditures that do not benefit the outpatient or improve the quality of his care in any way.

In the nation, and particularly in Alabama, there is an excess number of hospital beds. This has proven to be inflationary. We will see these beds used more efficiently and appropriately in the very near future. This combined with a healthier patient population will make the excess even more obvious. Physicians must work with hospital groups, third party payors, and government to find an equitable way to remove excess beds from the bedpool so that the cost for these beds is not figured into the per diem cost to the patient.

The Birmingham Steering Committee, composed of physicians and representatives from the business community, has formed a coalition that is actively working on the cost of health care problems. Such arrangements should be encouraged. There are now some forty-five business-medicine coalition groups across the country, all working nicely.

However, there are sixty business-business groups which do not have input from the medical profession. They are addressing the problems of contemporary medicine from a cost basis only with no concern for accessibility and quality. Physicians must find a way to be included in the discussions of these groups.

But for physicians to be effective in such deliberations, they must become educated. We must learn the intricacies of reimbursement mechanisms as well as the other facets of the current system. Also, we must be adaptive to change and be willing to commit the time and energy required.

There are three kinds of people: those who make things happen, those who watch things happen, and those who wonder what did happen. In Alabama we have many people who can make things happen. Working together, we can achieve great things, even redressing the inequities of our current system of delivering medical care.

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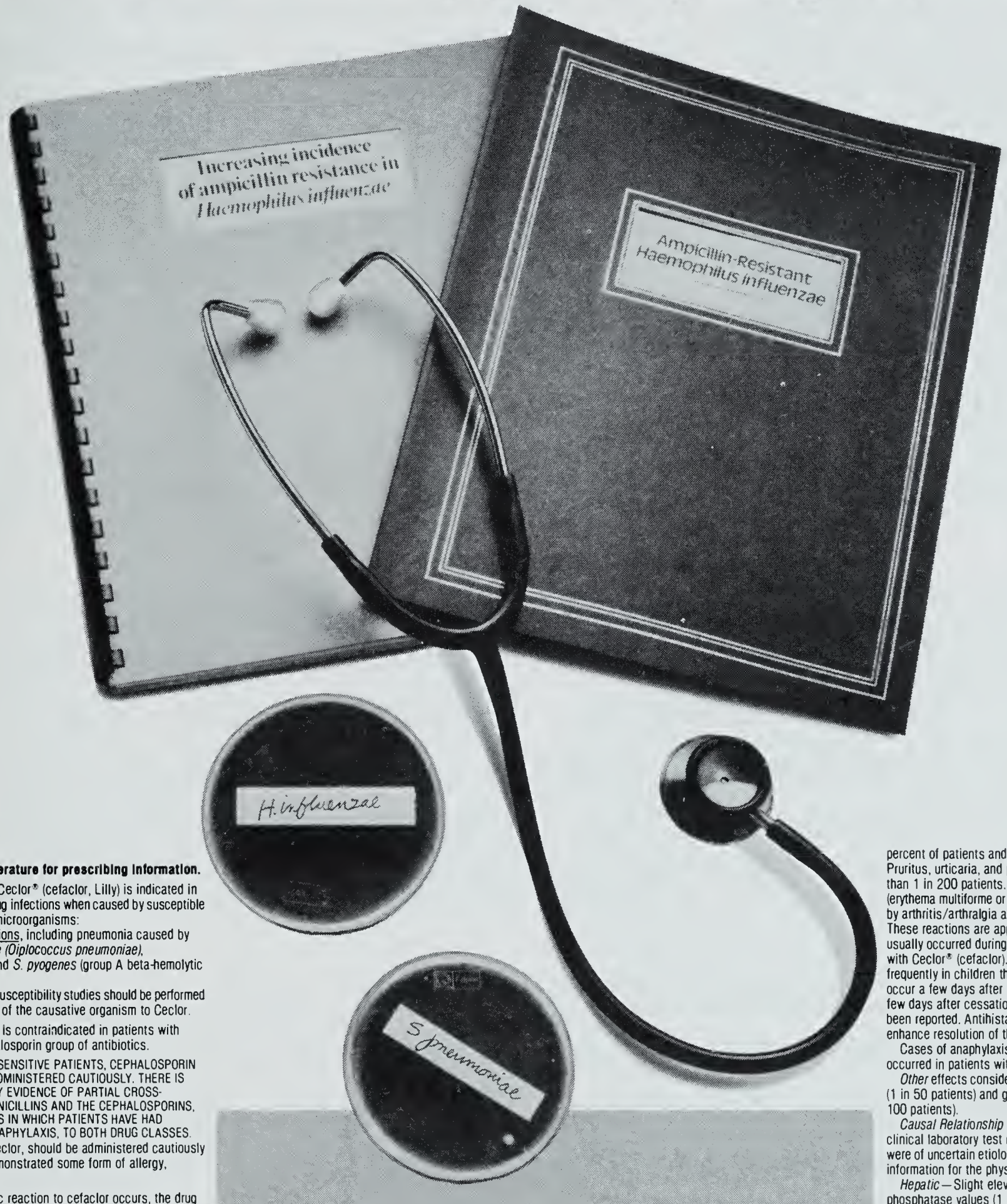
An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, TES, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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'Operation for Aneurism of the Axillae' — 1834 A Historical Notation

Ronald D. Greenwood, M.D.*

In 1834, Dr. A. G. Smith of the faculty of the Medical College of Ohio, Cincinnati, successfully performed a vascular operation on an arterial aneurysm in the axilla. He reported his operation in *The Western Medical Gazette* on March 1, 1834:

Lewis Verque, a native of Spain, aged 30, while passing up the Ohio, was wounded with a dirk knife, on the anterior portion of the deltoid muscle, the knife entering near the point of the shoulder, passing inwards and forwards, so as to wound the axillary artery, as it emerges from under the clavicle. — The artery bled largely at the time, and at several periods afterwards, but ceased entirely in a few days, and shortly after the wound healed. He applied to me in September, 1832, four weeks after the injury. Upon examination, a tumor about five inches across its base, presented itself pulsating strongly, just under the left clavicle. His general health was feeble and impaired. He was unable to use his left arm, and was confined to his bed, and any sudden motion of the body, produced a blindness and faintness. I sent him to the Hospital, put him upon low diet, and applied pressure to the part for two or three weeks, but finding the tumor increasing, on the 3d of October, in the presence of several physicians, I took up the subclavian artery in the following manner; pinching up the skin directly over the part where the artery passes over the first rib, I made an incision with the Bistoury along the upper margin of the clavicle, three inches in length, then turning the bistoury upwards, I made another incision perpendicular to the first, about two inches in length. Keeping on the outside of the external jugular vein, I continued my incision down through the platisma myoideus muscle, making the lower edge of the omo hyoideus muscle my guide, until I came to the artery as it comes through the scaleni muscels. After separating the sheath, I introduced 3 cords of silk underneath it, from above downwards, with the needle recommended by Dr. Parish and secured the knot with my fingers, finding them more convenient than any instrument recommended for that purpose. Immediately the pulsation ceased in the tumour, and it diminished in size one third; the pulsation in the radial artery which was before scarcely perceptible, ceasing entirely. There were no vessels wounded in the operation that required a ligature, and there was not a gill of blood lost. The wound was simply dressed with Emp. Adhe. & c., and the arm enveloped in flannel. There was a slight cool perspiration over the arm for about forty-eight hours after the operation. On the sixth day there was a feeble pulsation in the radial artery. On the eighth the ligature came away with the dressing. On the fifteenth, the wound was healed, the tumor nearly gone, and what remained was a hard mass. On the eighteenth he returned to N. Orleans, and was rapidly recovering the use of his arm.

This simple procedure by present standards was a significant accomplishment nearly 150 years ago. Rehn, who first successfully sutured a heart wound, was not yet born and although operations upon simple vascular injuries had been performed these were rare and not always successful.

Not until the last years of the nineteenth century would arterial suture repairs be done with any frequency and not until the early twentieth century would more radical approach to aneurysms be used.

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1. Smith, A. G.: Operation for Aneurism of the Axilae. The Western Medical Gazette 1:36, 1834.
2. Guthrie, C. C.: Blood-Vessel Surgery and Its Applications. London, Edward Arnold, 1912.

Acknowledgement

I am indebted to The Francis A. Countway Library of Medicine, Harvard Medical School, for use of their historical materials.

* Qual Lakes Plaza, 2291 W. March Lane, No. 199-D, Stockton, California 95207.

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Partners In Health

Mrs. Patty Estock
President, A-MASA

The term, partner, is defined as ''one who takes part in an activity with another sharing its successes and risks.'' The term, auxiliary, is defined as ''giving assistance or support, aiding, helping, supplementary.'' This year let us think of the Medical Association and our Auxiliary as ''Partners In Health.''

As auxilians we are strongly committed to uphold the Medical Association of the State of Alabama, respect its principles, and help promote its interests and programs. The goals of the auxiliary in this partnership are:

- Improve the health and quality of life for all people,
- Promote health education,
- Encourage volunteer participation in activities that meet health needs and
- Support health related charitable endeavors.

The attainment of these goals requires that we work at several levels of partnership. The basic level is in the marriage to our physician spouse. The medical marriage has special needs and unusual pressures. Physicians have had to expend more energy, time and money to attain their goals than most people. They bear a much heavier responsibility in the real everyday world than a cab driver, accountant, attorney, or any other professional or businessman or worker.

Every patient's encounter with the physician is very important to that patient. People's happiness, security, and future depend upon the physician's decisions. Physician spouses also lead different lives from their neighbors. We experience pressure and demands on our emotions and time which others do not. The task of accepting these differences and enjoying each others growth and varied achievements is an ongoing challenge to every married couples' maturity.

The next level of partnership necessary for the attainment of these goals is our partnerships within the auxiliary itself. We are partners at the county organization level, we are partners at the state organization level and we are partners at the national organization level.

The final level of partnership which we must not forget is our individual partnership with our Creator. From this partnership we gain continuing inspiration toward our full potential and strength to carry out our efforts in all our other levels of partnership.

Our challenges are clear. We must improve upon the good that has come to us from the past and pass it on to those who follow us. To reach our full potential, we must have positive attitudes, strong leadership, determination, a willingness to affect change and a strong desire to grow. This can be assured only by diligently working in all our partnerships — especially our task as ''Partners In Health.''

Beyond our organization itself lies another level of partnership — that with our communities. As physician spouses we have a very special ability to lead others in matters that relate to health because we have channels for getting information, finding out what needs to be done, and helping to motivate others to act. The President of the United States has said, ''We are shifting responsibility away from the federal government, but to do so requires that the needs of people be met at the local level.''

The local or community level is exactly where auxiliaries are, ready and waiting for their tremendous potential to be utilized. As government budget cuts phase out programs and services our auxiliary can step in. Community health services and education efforts need to continue. Medical auxiliaries, working in partnership with local governments, their medical societies and other volunteer groups can establish new ways of meeting these needs.

President Reagan has also stated, ''Our nation's resources and values and our freedom to act voluntarily for the ideas and ideals we believe in are the most important aspects of our lives.''

Patty

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Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy

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in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae.* To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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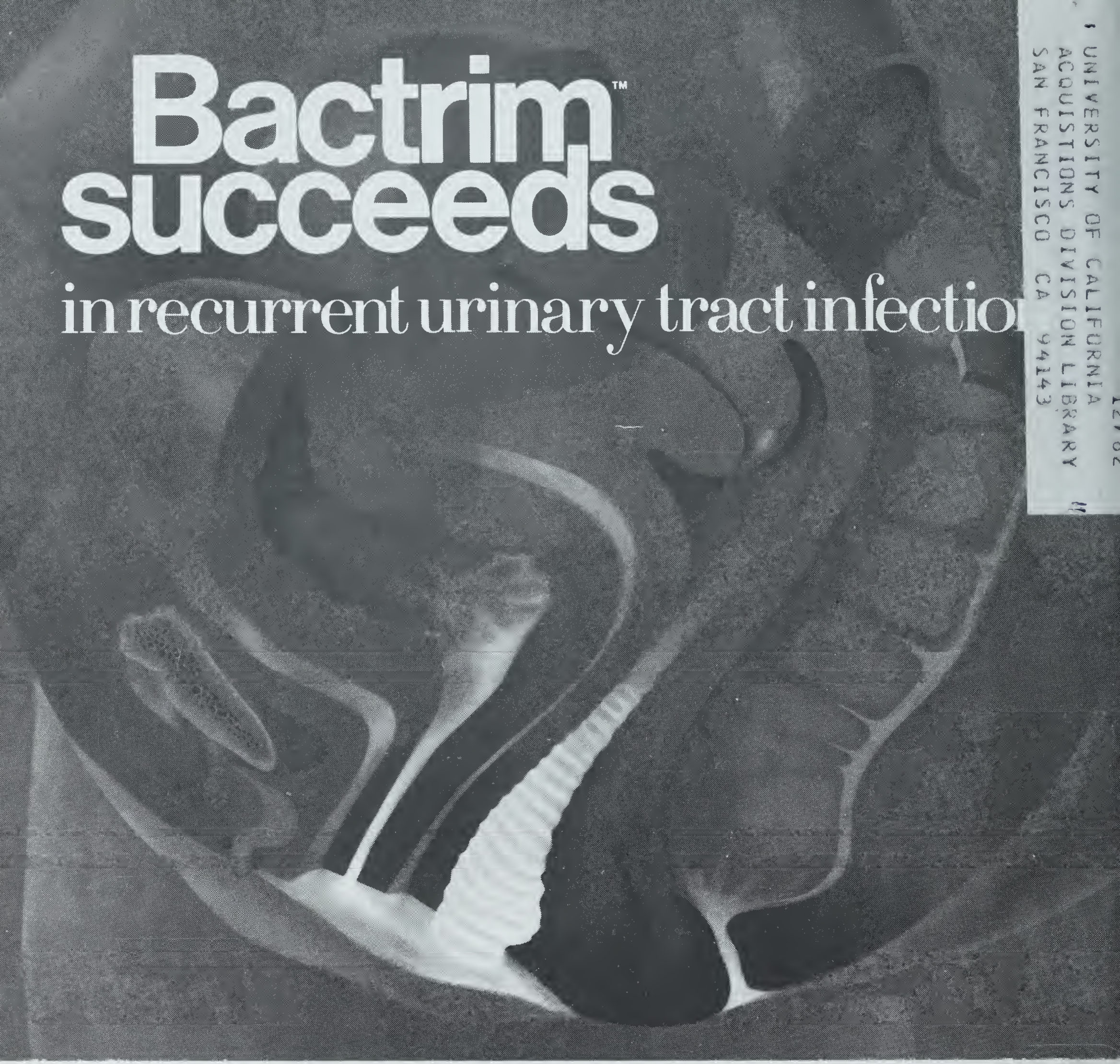

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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med 303:*426-432, Aug 21, 1980..**2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

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Please see previous page for summary of product information.

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WHAT IS MASA'S BUSINESS

see page 9

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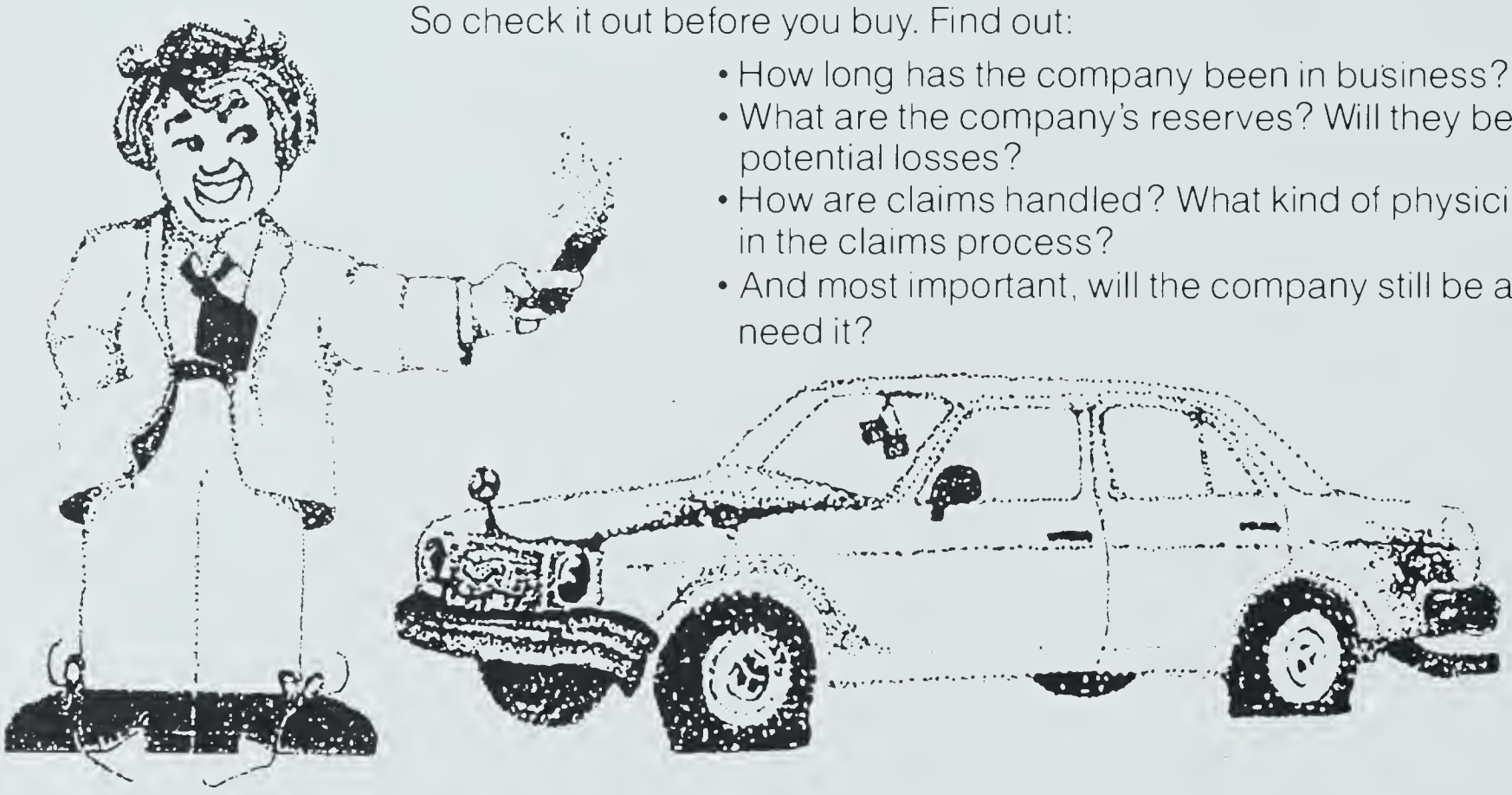

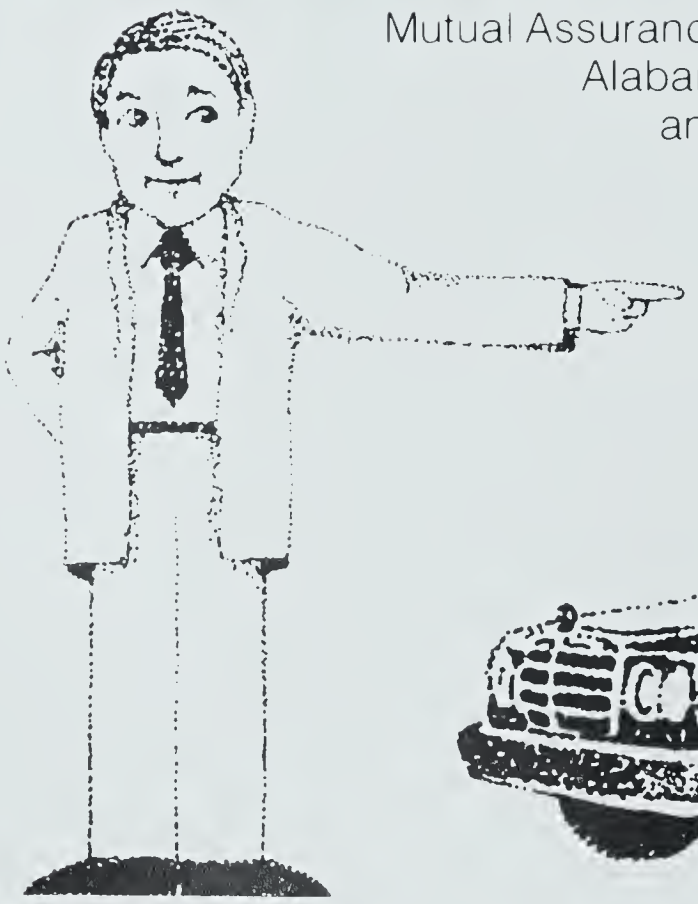

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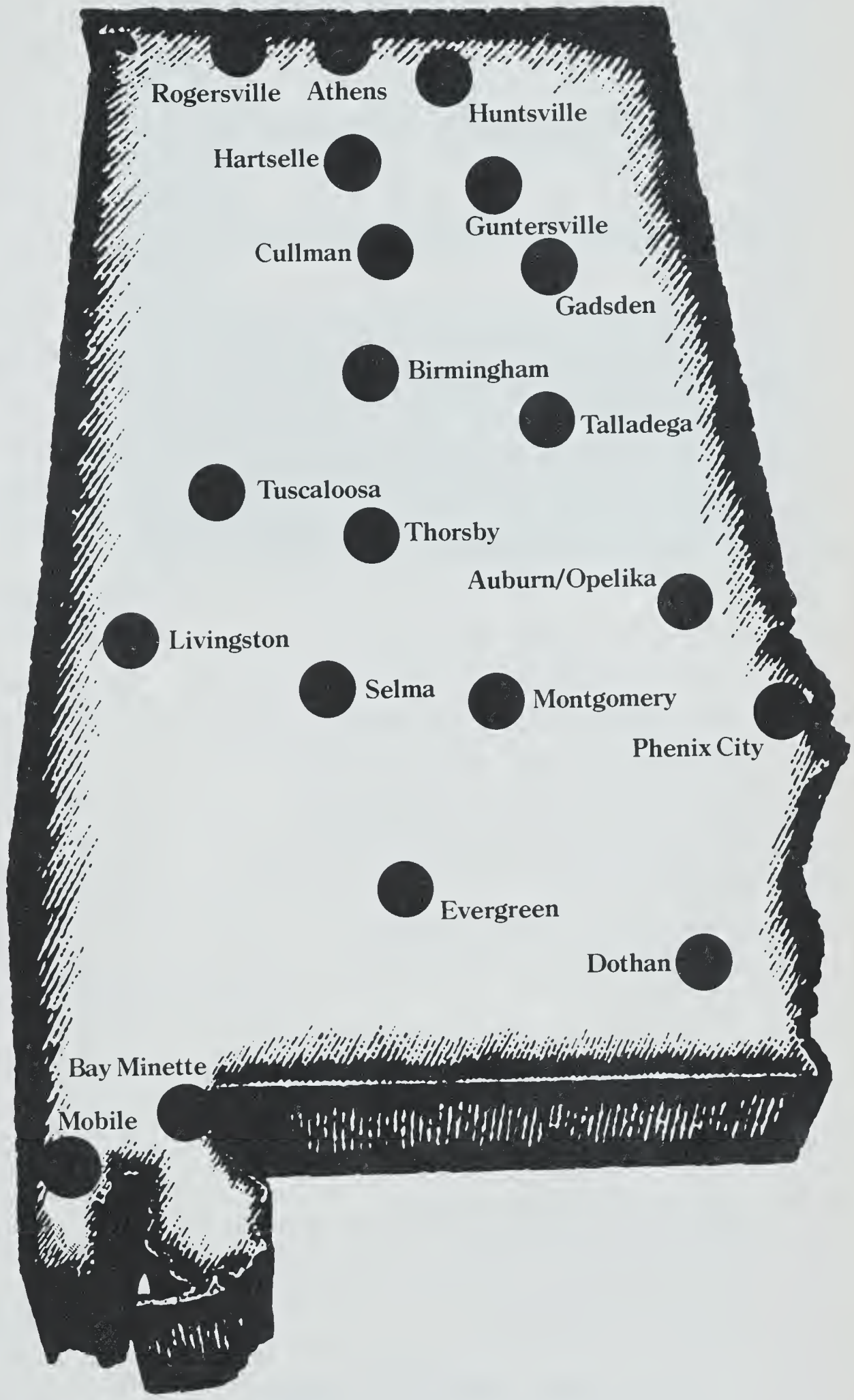

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EXECUTIVE DIRECTOR

S. Lon Conner
Executive Director, MASA

Medical Saber Rattling?

Some physicians may have become so inured to the constant drumfire of warnings from their elected leaders about the political and economic encirclement of organized medicine they have tuned out.

A few, for example, have been heard to admit that the leadership cries wolf so often their credulity is taxed, and they no longer pay much attention.

I certainly agree with the editorial comments of Edward Pedero, Jr., M.D., of Florida, reprinted in the April JOURNAL, when Dr. Pedero acknowledged that it is impossible to frighten physicians into supporting their state and national associations, just as it's impossible to frighten the general population into building a nation-wide bomb shelter system.

Americans, physicians and non-physicians alike, simply don't scare easily, which can be both good and bad. It's bad if you allow apathy to control your thinking; or the belief that it can't happen here; or the fatalistic assumption that if doomsday is coming, it will come anyway, and there is nothing to be done about it.

As in preparation for national survival, the defenses necessary for the survival of the free practice of medicine are absolutely essential. Those who are not interested in the effort, preferring to be left in peace, cultivating their garden, should at least be glad that many outstanding physicians are there on the barricades every day.

Do you know, for example, what the AMA's Washington lobby faces across the trenches? There are literally scores of other groups pouring money and manpower into the nation's capital, usually with objectives entirely at cross purposes to the best interests of American patients and their physicians.

To take only one example, that of government itself:

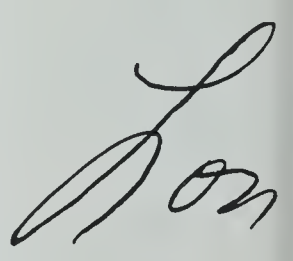
The Department of Health and Human Services has the largest lobbying budget in the federal government, excluding that of Defense. According to a General Accounting Office audit, in 1981 HHS had 12 congressional liaison offices, with a staff of 178 and a budget of $7 million.

Perhaps you didn't realize that the government lobbies the government, but it does. Frequently these bureaucratic efforts, usually dedicated to expansion of the federal monolith, are joined with and amplified by those of other groups with similar expansionist objectives. Washington fairly teems with gimme-gimme groups eager to socialize the finest health care system in the world for their own short-sighted purposes.

Here in Alabama, there was a time not so long ago when MASA's lobbiest, Dickey Whitaker, had to contend with only one or two opposing groups in the Legislature. Now there are many, the number going up every time he stops to count. His job is proportionately as great as the AMA faces in the Washington battle zone.

Every day, in many different ways, the noose tightens around medicine. That means that every day all of us, physicians and staff alike, must struggle harder to save what we are utterly convinced is a priceless heritage of Americans, some of whom have no idea of its value because they have never lived under another system. Sustained by this ignorance, they are easily led by those who want to throw the baby out with the bath.

If you are among the physicians who still believe the battle is not in earnest, and that the survival of your patrimony from your professional antecedents is not at stake, there is probably no way I can convince you. I can only plead that you give at least nodding approval to the foot-slogging troops in the line — your fellow physicians and their support personnel. ⊡



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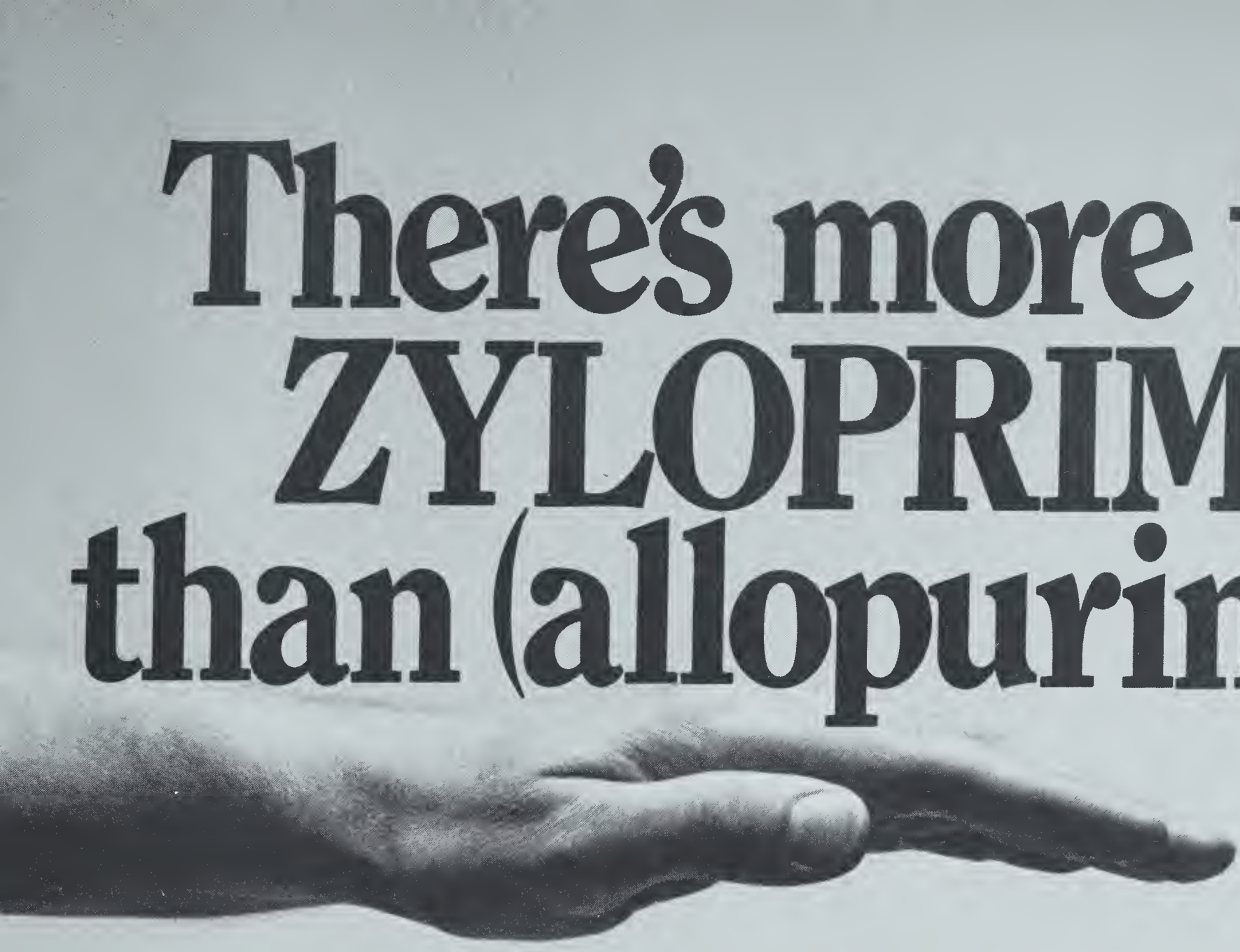

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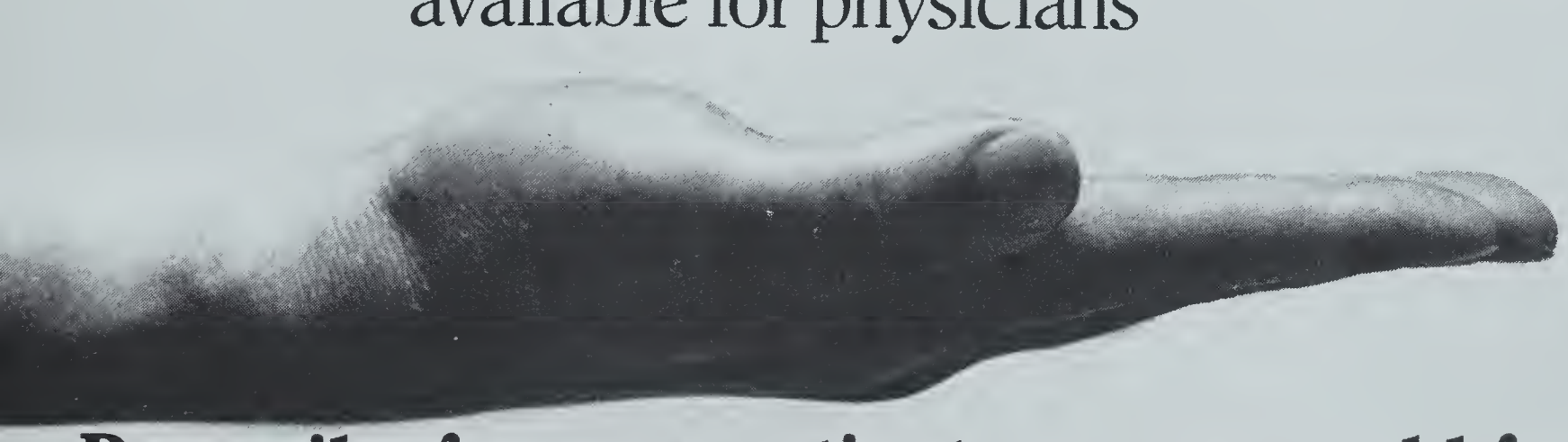

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anorexia
feelings of guilt and worthlessness
fatigue
palpitations
headache
vague aches and pains
sadness
psychic and somatic anxiety

Artist's conception,
looking out from the human eye
as conceived in a schematic model

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Warnings: Use with great care in patients with history of urinory retention or angle-closure glaucoma Severe constipotion moy accur in potients taking tricyclic antidepressants and anticholinergic-type drugs Closely supervise cardiovascular patients (Arrhythmias, sinus tochycordio ond prolongotion of conduction time reported with use of tricyclic ontidepressants, especiolly high doses Myocordiol inforction ond stroke reported with use of this class of drugs) Coution potients obout possible combined effects with alcahol ond other CNS depressonts ond ogoinst hozordous occupations requiring complete mentol olertness (e g , operoting mochinery, driving)

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Adverse Reactions: Most frequently reported are thase ossocioted with either component olone: drowsiness, dry mouth, constipotion, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion ond nosal congestion. Mony depressive symptoms including onorexio, fotigue, weakness, restlessness ond lethorgy have been reported os side effects of both Limbitrol and omitriptyline Granulocytopenio, joundice ond hepotic dysfunction have been observed rarely

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Psychiatric Euphoria, apprehension, poor concentrotion, delusions, hallucinotians, hypomania and increased or decreosed libido

Neurologic Incoordinotion, ataxia, numbness, tingling ond poresthesios of the extremities, extropyramidol symptoms, syncope, chonges in EEG potterns

Anticholinergic Disturbonce of occommodotion, porolytic ileus, urinary retention, dilotation of urinory troct

Allergic Skin rosh, urticaria, photosensitizotion, edemo of foce and tongue, pruritus

Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpuro, thrombocytopenio

Gastrointestinal Nauseo, epigostric distress, vomiting, anorexia, stomatitis, peculior toste, diarrhea, black tongue

Endocrine Testicular swelling and gynecomastia in the mole, breast enlargement, galactorrhea and minor menstrual irregulorities in the femole ond elevation and lowering of blood sugar levels

Other Headache, weight gain ar loss, increased perspirotian, urinory frequency, mydriasis, joundice, alopecio, parotid swelling

Overdosage: Immediately hospitolize potient suspected of having taken an overdose Treatment is symptomatic and supportive I.V administrotion of 1 to 3 mg physastigmine solicylote hos been reparted to reverse the symptoms af amitriptyline poisoning See complete product information for manifestotion and treotment

Dosage: Individualize according to symptom severity ond potient response Reduce to smallest effective dosoge when sotisfactory response is obtoined Larger portion af daily dose may be taken at bedtime Single *h.s.* dose may suffice for some potients Lower dosages ore recommended for the elderly Limbitrol 10-25, initial dosage af three to four tablets daily in divided doses, increased to six tablets or decreased to two toblets daily os required. Limbitrol 5-12 5, initiol dosage of three to four tablets daily in divided doses, for patients who do nat tolerate higher doses

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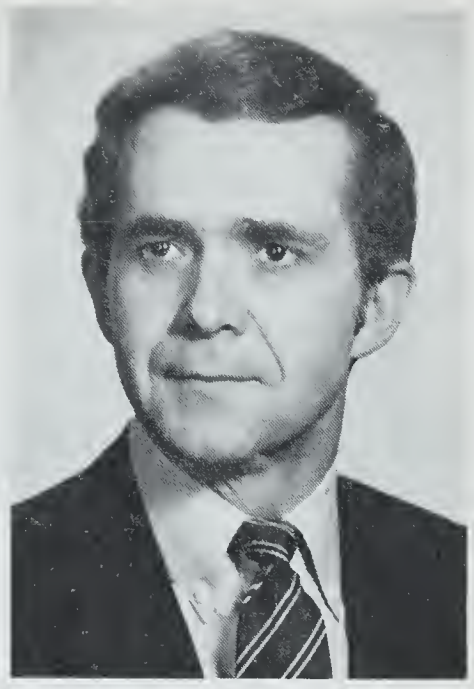

Ronald E. Henderson
President, MASA

What Is MASA's Business?

In the middle 1950s, Peter Drucker propounded a now famous question that earned a permanent place in management theory. In his book, *The Practice of Management,* the renowned corporation consultant asked this deceptively simple question of all businesses, industries and organizations: "What is our business? What should it be?"

American corporations have since devoted thousands of man/hours to answering that question, believing the answer to be essential to their survival. Those that failed have been swallowed up or have disappeared without a trace.

From scholarly journals to the factory floor, the question has been debated by all manner of organizations for three decades. The critical importance of a question that seems so obvious at first blush is recognized far beyond the production of tangible goods. Even some churches have attempted to answer it.

Mr. Drucker was categorical in his belief that those who failed to answer the question satisfactorily are doomed, as the Packard Motor Car Company, a classic example of a corporation that forgot what business it was in. The Packard case is instructive.

Packard was a quality prestige car of its day, second only to Cadillac. It survived the great depression, because the company had shrewdly discerned that Packard buyers were buying more than a solidly constructed, carefully engineered car. They were buying, as Drucker noted, "conservative solvency and security in an insecure world." The Packard stood for quiet quality, genuine worth and integrity, without the ostentation of the Cadillac.

It worked, until Packard forgot that its business was determined by its market. Times changed; Packard did not. Near the end of its independent existence it began thinking that it was in the business of competing with Chevrolet and Ford, when, as Drucker noted, "It was actually trying to compete with diamonds and mink coats." Diamonds and mink coats won, because Packard no longer knew what business it was in.

Now, with this brief illustration, you can see what Drucker was up to in his famous question, one that still haunts every corporation in America. The market determines what business you are in, according to Drucker's thesis, not you. And partly as a result of Drucker's question, market research is today a huge industry, the listening post of corporations trying to decide every day and every year what business they are in. Some, like the ghost of Packard, still refuse to ask, attempting instead to force on the market their own convictions and taste, the public be damned. It won't work, but some insist on learning the hard way.

Since other organizations dealing in intangibles have embraced the Drucker question, why should not The Medical Association of the State of Alabama? Individual physicians, I think, have little trouble answering the Drucker question — we know what we do — but it becomes more difficult when we ask the question of ourselves collectively: "What is the business of MASA? What should it be?"

Applying Drucker's question in this context, we see that more than 4,000 members of the Association constitute MASA's market. You determine what business the Association is in, the shape of the final product, all that goes into the mix. You also determine what it should be.

To find out what you think, we have caucuses and

continued on next page

annual sessions to listen to your thoughts and judgment, the moral equivalent of market research, perhaps. Association officers are, after all, your elected stewards, charged by oath to carry out your instructions; but if you have no instructions, if you decline to tell us what you think, how are we to know?

The founders of our Association knew without hesitation what business they were in when they created MASA. Pestilence and quackery were the norm rather than the exception. The public knew little of disease and sanitation; the political leadership, not much more. Public Health had to be developed from the ground up. Ignorance, which bred diseases and provided a fertile soil for those who preyed on human misery, had to be fought with education and enlightenment; the profession itself had to be lifted by the bootstraps of modern scientific education in the medical schools.

The roles, mission and objectives were never in doubt to men like Dr. Jerome Cochran, who became the first State Health Officer. Yet the tools they had, the scientific knowledge, drugs and vaccines were primitive by today's standards. They had little more than their own vision, their faith and their sense of purpose and calling. With these simple yet powerful instruments they built out of the destitution of the 19th century an Association dedicated to patient care, public awareness and professional standards without equal in the world.

A vogue word these days, drawn from thermodynamics, is *entropy*. Entropy in this metaphorical sense is that late stage in the life cycle of an organization or system when its energy is expended in all directions, chaotically, as the system loses momentum and slowly begins to wind down.

The opposite of this choas, in the entropy analogy, is communication. That organization which knows what business it is in, because all elements communicate in harmony with each other, remains alive and well.

I ask you, as I ask myself, "What is MASA's business? What should it be in contemporary society in the 1980s?" Should we be self-serving and act, as most unions, along purely economic threads, or should we extend the patient advocacy concept from the individual doctor-patient situation to a larger context with the Association continuing to stand for what is best for the patient and the public good? And should we react with other "special interest groups" and take adversary positions when their efforts run counter to what we feel is in the best interest of the public's health? These are my questions to you.

If organized medicine at any level stops asking the question every day and every year, it could end like Packard — a high quality, unquestionably superior organization that forgot its purpose. ⊡

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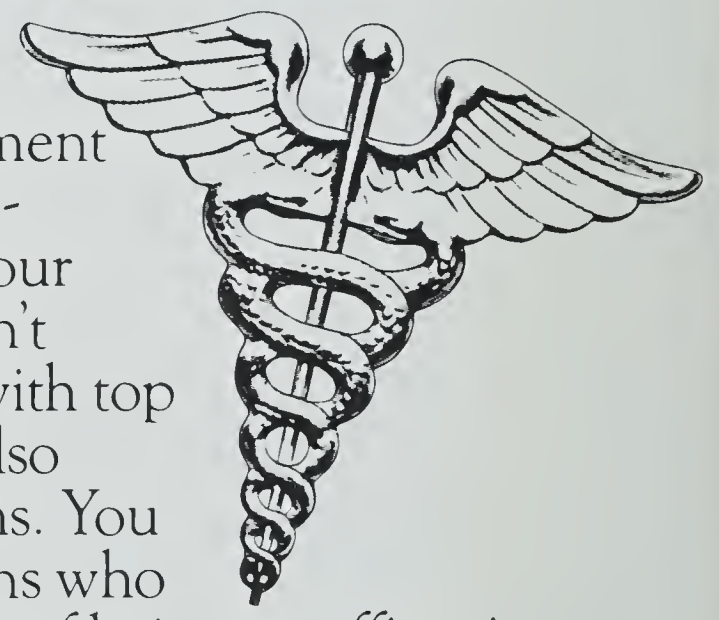

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In the excellent exposé *Nutrition Cultism* the modern food quack is aptly described as a ''supersalesman'' whose yearly ''take'' involves billions of dollars. ''He plays on your fears. He caters to your hopes. And once he has you, he keeps you coming back for more — and more — and more. Seldom do his victims realize how often or how skillfully they are being cheated.''[1] Physicians are well aware of the many nutritional hoaxes perpetrated on the public in the guise of ''miracle'' foods. In this country it is perfectly legal to make untrue and even outlandish nutritional claims provided that these claims are not included on a product's label.[1, 2]

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* Professor of Internal Medicine and Family Medicine, College of Community Health Sciences, University of Alabama.
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‖ Associate Professor of Biology, University of Alabama.

Case Report

A 65-year-old white female presented to the Emergency Room with dyspnea and wheezing. She had suffered from seasonal rhinitis and asthma since her teens, and claimed to be sensitive to ragweed, chrysanthemum and bee stings. She had a positive family history for asthma. Her chronic asthma was controlled with prn use of Isuprel spray and Primatene tablets. She had not had an asthmatic attack requiring medical attention for 10 years. The patient denied any history of recent respiratory tract infection or exposure to any known allergens. Her only other medications were aspirin for arthritis, and Vicks 44D cough syrup. She denied chest pain, orthopnea, PND or edema. Further history revealed that she had been fatigued and tired since her mother's death six months previously and she had attributed her ''lack of pep'' to a grief reaction. In order to regain her vigor she purchased ''energized'' bee pollen which she had begun to take approximately 10 days prior to her hospital admission. During this time she had noted increasingly severe asthmatic symptoms, refractory to her usual treatment regimen. She denied hematemesis but admitted to occasional dark stools which she felt were related to beets or spinach in her diet.

Examination revealed a pale, well nourished white female in moderate respiratory distress. She was audibly wheezing, using accessory muscles of respiration, and sitting upright to breathe. Conjunctivae were pale.

HYPERTENSION:

METHYLDOPA? RESERPINE? INDERAL?

COUNTLESS THOUSANDS WOULD BE BETTER OFF WITH

INDERAL®

(PROPRANOLOL HCl) B.I.D.

The sooner, the better.

Today, INDERAL—instead of methyldopa, instead of reserpine.

INDERAL exhibits few of the disturbing side effects of methyldopa and reserpine. Sedation, depression, and impotence are rare.* Tolerance is not likely to occur, as it frequently does with methyldopa. For the vast majority of patients—INDERAL means a step toward improving the quality of life. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.)*

INDERAL blocks beta-receptor sites *in the heart* to reduce heart rate and cardiac output—reducing cardiac work load—sparing an overburdened heart.

Hypertensive hearts can rest easy with INDERAL. For many—it is ideal, first-step therapy.

INDERAL—the sooner, the better for hypertension—a leading risk factor in coronary heart disease.[1]

*Please see following page for Brief Summary of Prescribing Information.

THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

INDERAL®
(PROPRANOLOL HCl)
B.I.D. FOR HYPERTENSION

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

Inderal® BRAND OF **propranolol hydrochloride A beta-adrenergic blocking agent**

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in 1) bronchial asthma; 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

WARNINGS

CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (*i.e.*, that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn. b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY: beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, *e.g.*, isoproterenol or levarterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (*e.g.*, CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY: The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia; congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DOSAGE AND ADMINISTRATION

ORAL

HYPERTENSION—*Dosage must be individualized*: The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, *e.g.*, LEVARTERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E. D. Hypertension (Suppl. II) *3*: 230 (Nov.-Dec.) 1981

7997/482

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Chest expansion was good bilaterally. Tactile fremitis and percussion were normal. Auscultation revealed loud wheezing throughout both lung fields. Sinus tachycardia was present. The rest of her physical examination was essentially normal.

Initial laboratory data revealed a red-cell count of 3,480,000 per cubic millimeter, white-cell count of 8,100 per cubic millimeter, hemoglobin was 6.5 g per 100 ml, hematocrit was 22.4 g per 100 ml, mean corpuscular volume was 64 μm^3, mean corpuscular hemoglobin was 18 pg, and the mean corpuscular hemoglobin concentration was 39%. White-cell differential was 78% neutrophils, 1% bands, 13% lymphocytes, 4% monocytes and 4% eosinophils. Arterial blood gases on room air were pH 7.5, pCO_2 32.2 mm Hg, pO_2 62.8 mm Hg and HCO_3 24.6 mEq/l. EKG showed sinus tachycardia and chest x-ray revealed no infiltrates. Stool for occult blood was positive.

She was admitted for evaluation of anemia and treatment of her asthma. Upper G.I. studies revealed a large hiatal hernia. Barium enema showed numerous diverticuli throughout the colon. Her test for occult blood became negative after three days of cimetidine and antacid therapy. Gastroscopy was aborted when the procedure induced severe bronchospasm. In addition to parenteral aminophylline and terbutaline, steroid therapy was initiated. Her asthma resolved over a 10 day stay and she was discharged on theophylline, terbutaline and a tapering dose of prednisone. Iron therapy produced a good reticulocyte response and the patient was continued on cimetidine and antacids. She was instructed to refrain from taking bee pollen tablets as well as aspirin-containing products. At a two-week outpatient follow-up visit the patient was free of wheezes. Prednisone, terbutaline, cimetidine and antacids have been discontinued. Her anemia continues to improve on iron therapy and tests for occult blood have remained negative.

Discussion

This case illustrates potential problems which can result from reliance on ''health'' products, such as bee pollen. The gastrointestinal abnormalities noted as well as aspirin use most likely induced the patient's microcytic anemia. Instead of seeking medical attention for her progressive fatigue, the patient relied on bee pollen to which near miraculous properties have been attributed.[3-7] Bee pollen purveyors and ''authorities'' often cite uncontrolled studies purporting to show a beneficial effect of pollen in anemic subjects.[5, 8] Similarly, use of bee pollen is often recommended for atopic individuals. Binding, for example, has stated ''Certain pollens may cause allergies, but to repeat what I have already stressed, those pollens collected by bees do not. Bee-gathered pollen may safely be taken by everyone, even those persons prone to allergies such as hay fever, as they will suffer no ill-effects from the pollen.''[5] A ''nutrition'' publication states that ''because of its protein content, pollen raises the gamma globulin level. These substances held build the body's natural immunity and protect against allergic reactions.''[8]

Despite myriad other unfounded simplistic claims for ''the world's perfect food'' several untoward reactions have been reported in the orthodox medical literature. Cohen and colleagues described three patients who developed severe immediate allergic reactions after ingesting bee pollen. All the patients had an atopic history with seasonal rhinitis. On examination, the pollen was found to contain the family *Compositae*. Members of this family include dandelion, ragweed, sunflower, chrysanthemum and numerous herbs and spices. Cohen, et al, documented by both *in vivo* and *in vitro* studies that their patients were sensitive to several members of the *Compositae* family.[9] More recently, Mansfield described severe systemic reactions in several allergic patients who ingested bee pollen.[10]

Noyes, et al, described three patients who developed bronchospasm after eating sunflower seeds. All the patients had a history of perennial rhinitis and one had a history of asthma.[11] As noted, sunflower is also a member of the *Compositae* family.

The Medical Letter recently stated that ''many plant products sold in health food stores can cause toxic effects, including some that are potentially lethal. Possible hypersensitivity reactions to herbal teas made from members of the *Compositae* family were discussed, as was the development of an anaphylactic reaction in a ragweed-sensitive asthmatic after ingestion of chamomile tea.''[12]

The patient in the present report had a history of sensitivity to members of the *Compositae* family and, as in the above reports, had long-standing rhinitis. The bee pollen tablets that the patient was ingesting were submitted to a detailed botanical analysis. Ten different pollen types were identified. The *Compositae* family composed 44% of the total pollens analyzed.

Comment

Jarvis and Barrett aptly noted that ''Since ancient times, man has sought at least four different ''magic potions'': the love potion, the fountain of youth, the cure-all and the athletic superpill. Quackery has always been willing to cater to these desires. It used to offer unicorn horn, special elixirs, amulets and magical brews. Today's products are vitamins, bee pollen, ginseng, Gerovital, pyramids, biorhythm charts and many more.''[13] None of the nutrients contained in bee pollen has any magical powers and all can be obtained readily and far less expensively in conventional foods.[1, 13] Claims of bee pollen's ''efficacy'' cover the gamut from aging, cancer, hemorrhoids, virility (it puts a sting in your stinger) — in short, virtually every disorder known to afflict mankind.[3-8]

Marilyn Stephenson, a nutrionist with FDA's

Bureau of Foods has stated that "claims or suggestions that certain health foods or diets prevent or cure disease or provide other special health benefits are, for the most part, folklore, and sometimes fabrication."[2] Many consumers are not aware that our Constitution's First Amendment places many claims about food and nutrition outside of Federal regulations through its protection of free speech and free press.[1, 2]

"Health" food products are, for the most part, expensive and unnecessary. Many have been shown to be actually dangerous, and deaths resulting from their use continue to be reported.[12] We are aware of several patients who have discontinued needed prescribed medications, instead relying on the claimed capacity of honeybee pollen to alleviate their symptoms. Others, such as the patient described in this report, delayed medical attention because of the misguided hope that "miracle" bee pollen would solve her problems. Instead, it more likely resulted in enhanced morbidity. We are aware of several other toxic reactions to bee pollen which have developed in local residents. All physicians would be well advised not only to acquaint themselves with the problems posed by so-called health foods and other dubious remedies,[1, 2, 13] but also to instruct their patients and the lay public on the potential dangers which can result from the use of quack remedies.

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Cyclapen®-W (cyclacillin)

Indications

Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*), *H. influenzae*, and Group A beta-hemolytic streptococci

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg t.i.d. body weight > 20 kg (44 lbs) 250 mg t.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day t.i.d.†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

How Supplied Tablets 250 mg and 500 mg in bottles of 100. Oral Suspension 125 mg and 250 mg per 5 ml in bottles to make 100 ml and 200 ml of Suspension.

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Compared to amoxicillin

Faster peak. Fewer problems.

. . . in infants and children

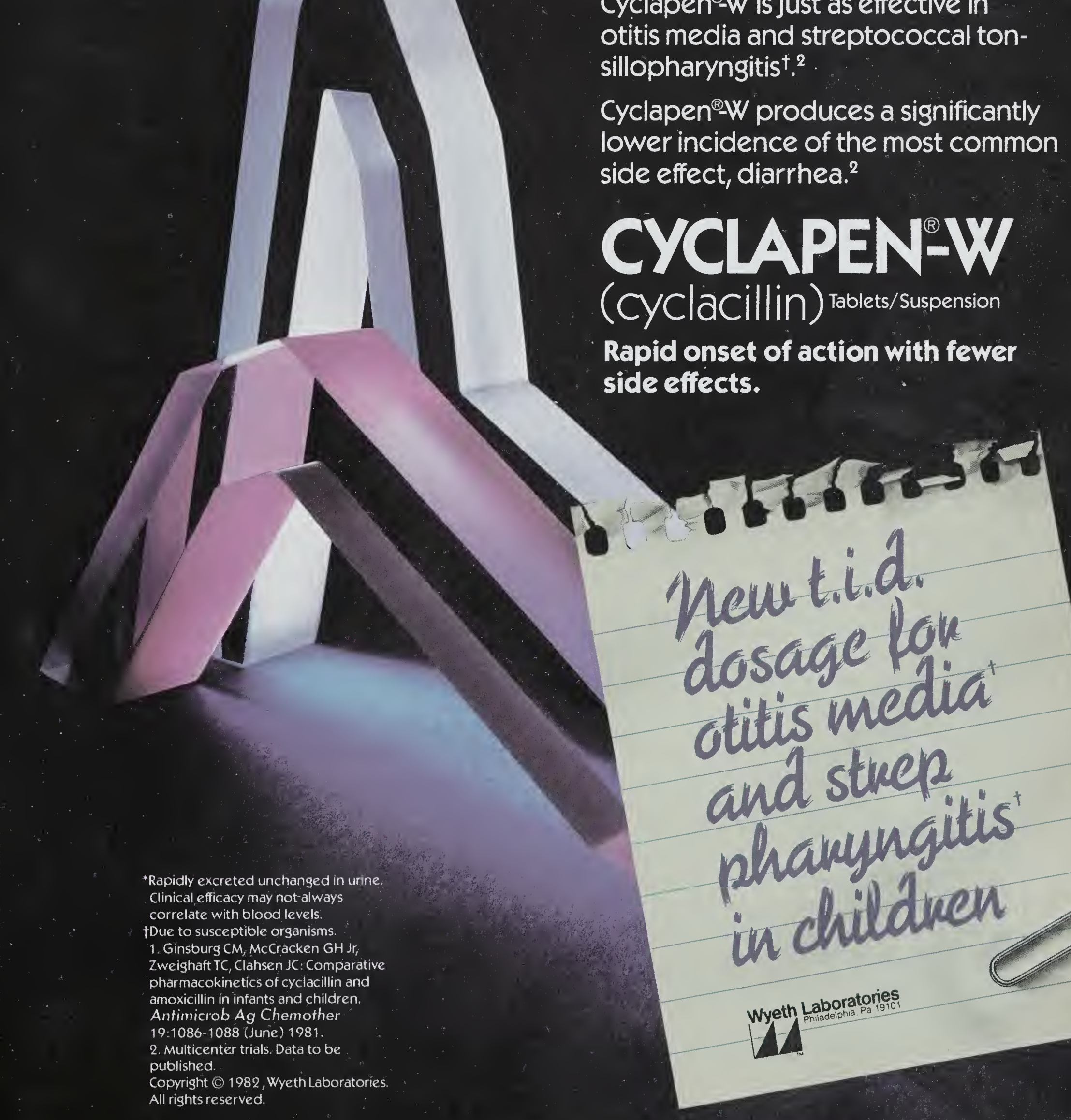
Cyclapen®-W (cyclacillin) produces twice the peak serum concentration* (15.6 mcg/ml versus 7.3 mcg/ml) in half the time (30 minutes versus 60 minutes).[1]

Cyclapen®-W is just as effective in otitis media and streptococcal tonsillopharyngitis†.[2]

Cyclapen®-W produces a significantly lower incidence of the most common side effect, diarrhea.[2]

CYCLAPEN®-W
(cyclacillin) Tablets/Suspension

Rapid onset of action with fewer side effects.



*Rapidly excreted unchanged in urine. Clinical efficacy may not always correlate with blood levels.

†Due to susceptible organisms.

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2. Multicenter trials. Data to be published.

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Quick in the Dark

Claude L. Brown, M.D.

That admirable master surgeon, Dominique-Jean Larrey, served the French Army valiantly and diligently; Napoleon called him "The most virtuous man I have ever known" and bequeathed him one hundred thousand francs. In an age when operative celerity was imperative Larrey was fast, fast: at Borodino he performed two hundred amputations in twenty-four hours. That may not be a record but it's a lot of ligatures. Working amid the appalling carnage of battle, from the sands of Egypt to the snows of Russia, he conceived the idea of "ambulance volantes," light vehicles that "brought the hospital to the wounded."

Our own "ambulance volantes" was a white Ford, two-door panel van which had a broken muffler, doors that never stayed securely closed, and whose driver was a madman. Its equipment was sparse: a four-wheeled cart that was designed to lock into a fixed position — the locking device was broken and the cart, once the vehicle was in motion, caromed frantically against the walls, the seats, and the rear doors; a Thomas splint; a policeman's night-stick; and a fishing tackle box filled with syringes, ampoules, needles, bandages, bits of string, cigarettes, and a whistle. The main driver, Flash Hopkins, was a lean, sandy-haired man, who viewed the public he served as generally nefarious, and the doctors whom he piloted as dolts. Our ambulance, in its decrepitude, inadequacy and halting suggestion of mercy-to-be-delivered, was fairly representative of the hospital. In the gore of the worst slaughter Larrey would have spurned this whole ensemble.

Only one month into my internship, I had ridden that ambulance six times with no supper. We could count on breakfast being good, with its fresh coffee, fresh napkins — or maybe it was just one's fresh appetite. Supper was different: I looked at the greasy liquid that didn't even smell like coffee, at the cringing pork-chops. My apathy made this fare look even worse but I was going to eat it. I had to, because being on first call meant that I'd not get another chance to grab anything all night. I reached for the fork, and Flash banged open the door, leaned half into the room, and chortled, "Put it down, Doc — we got to ride."

He would never learn; he didn't want to learn. We threatened him daily, urging him not to interrupt the few minutes of respite that meal-time afforded. Not him — he'd kick the door open sometimes, even when he had no call to report. "Just wanted to see if they're feeding you good," he'd leer. Nothing, including the staff dining room, was sacrosanct to Flash.

"Close the door gently from the outside, and hurry back in twenty minutes," I grumbled.

"No soap. We got to go now. Operator says somebody is bleeding bad." Quite probable. Somebody was always bleeding bad. In that narrow hospital world somebody was always bleeding, hurting, needing something desperately.

He had made it impossible for me to eat, but I refused to succumb so readily. With the pretense of not wanting to leave that tasty meal I said, ''I'm going to call Operator and see what she's talking about. It's probably nothing that can't wait — just someone run into a ditch, and wanting us to ride them back into town.''

Gertrude took her time answering my dial. ''What about this call? You know I'm trying to eat, and you send Flash to bedevil me. Quit bothering me. Tell them I'm in surgery, or that you can't find me at the moment.''

''Now, Doctor, that wouldn't be right. I couldn't lie for you.'' Many responses were possible but I was tired and repartee fled.

''The party that called said this woman was bleeding to death. They had no way to bring her to the hospital. And I've already told Sister that you're on the way.'' I could see her smirk. That settled the question; I hung up wordlessly.

Flash, triumphant, said, ''I've got the chariot at the emergency entrance.'' We walked up the stairs and out into the raw night.

''Where we going?''

''Some place down the bay — a few houses along a creek and a beer joint — it's called Snake Road. Somebody's probably caught his woman with another man and sliced her up. I know about where it is.''

We piled into the Ford and Flash gunned it out of the entrance drive. The siren was the one piece of equipment that always worked. He had strict orders not to turn it on until one block from the hospital when leaving, and to switch it off several blocks away when returning unless we were bringing in badly injured people. Naturally, he ignored such orders. He shifted into second, flicked on the siren's wail; we hurtled into Chestnut Street. Faint not, fair one — succor comes on swift wings, in the guise of a berserk machine.

In my frustration I had forgotten my coat. The drizzly January night was already cold, and the only heat was the negligible amount that blew through the rusted floorboards. Much fresh aid poured in, also, what with cracks everywhere, and the doors intermittently popping open. Automatically I looked around at the hospital, but instantly discarded the thought of telling Flash to go back for my coat. To return would look stupid. Damn that bastard!

The lights of the hospital receded rapidly; the old building seemed to dwindle and crumple on itself in the rain. Demands for medical attention were constant, clamorous. There were four interns and one resident. We set bones, operated, delivered babies, treated diseases identifiable and otherwise, and always and yet always we sewed up wounds. But the hospital seemed to rejuvenate itself from this flood of hurt human beings. They came, myriads, and usually were helped — in some fashion. It was rough, with worn out equipment and neophyte doctors who often attempted more, or less, than they should because they were half asleep, or frightened or dejected and confused — and because there rarely was anyone else to aid. The place was an ancient, sea-ravaged ship, ill-rigged and poorly manned, laboring to round a point in heavy weather. At the moment I was freezing, and the more I shivered the more heartily I cursed the hospital, Flash, and the hapless soul who supposedly was bleeding freely on Snake Road waiting our rescue.

Floorboarded, the ambulance would do just about seventy, so that was our usual speed. Flash was a marvelous and lucky driver; his being alive, intact, proved that. We flew towards a busy intersection, its bright red eye against us. Flash eased the accelerator only slightly, snapped his head left and right — an instant appraisal, and then full speed again. Somehow we careened across: one wildly rattling door swung

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wide open, tires screamed, horns blew, and I saw lips curl in curses, exclamations, and faces jerk into heart-stopping awareness of this juggernaut. We went through that intersection like the Numidian cavalry slashed through the Roman legions at Cannae. That siren never failed.

My hands shook from cold and fright. I fumbled out my cigarettes — no matches.

"Got a light, Flash?"

He unfastened the top button of his jacket, fished out a box of matches and handed it over. "Light one for me."

We smoked, shivering; I would just close my eyes and cross all fingers, but I would *not* say anything about his driving.

Traffic thinned on the outskirts of town. We swung off the highway onto a road with pock-marked paving, big pot-holes into which we slammed heavily. Flash turned off the siren. Shortly we turned into a vague, mucky lane that twisted between bushes and low-hanging branches that occasionally slapped wetly against the windshield. "Pitch black," said Flash. "I'll have to stop at the juke joint and find out which house. Somebody in there will know — it ain't but three, four houses, and then the road sorta quits."

The ambulance made a sliding stop at a dingy shack. A sign swinging in the wind and lit by a naked bulk, announced that this establishment was the Shady Inn.

"Real damned shady," grunted Flash. He ran over and hammered on the door. A rectangle of light as it opened —

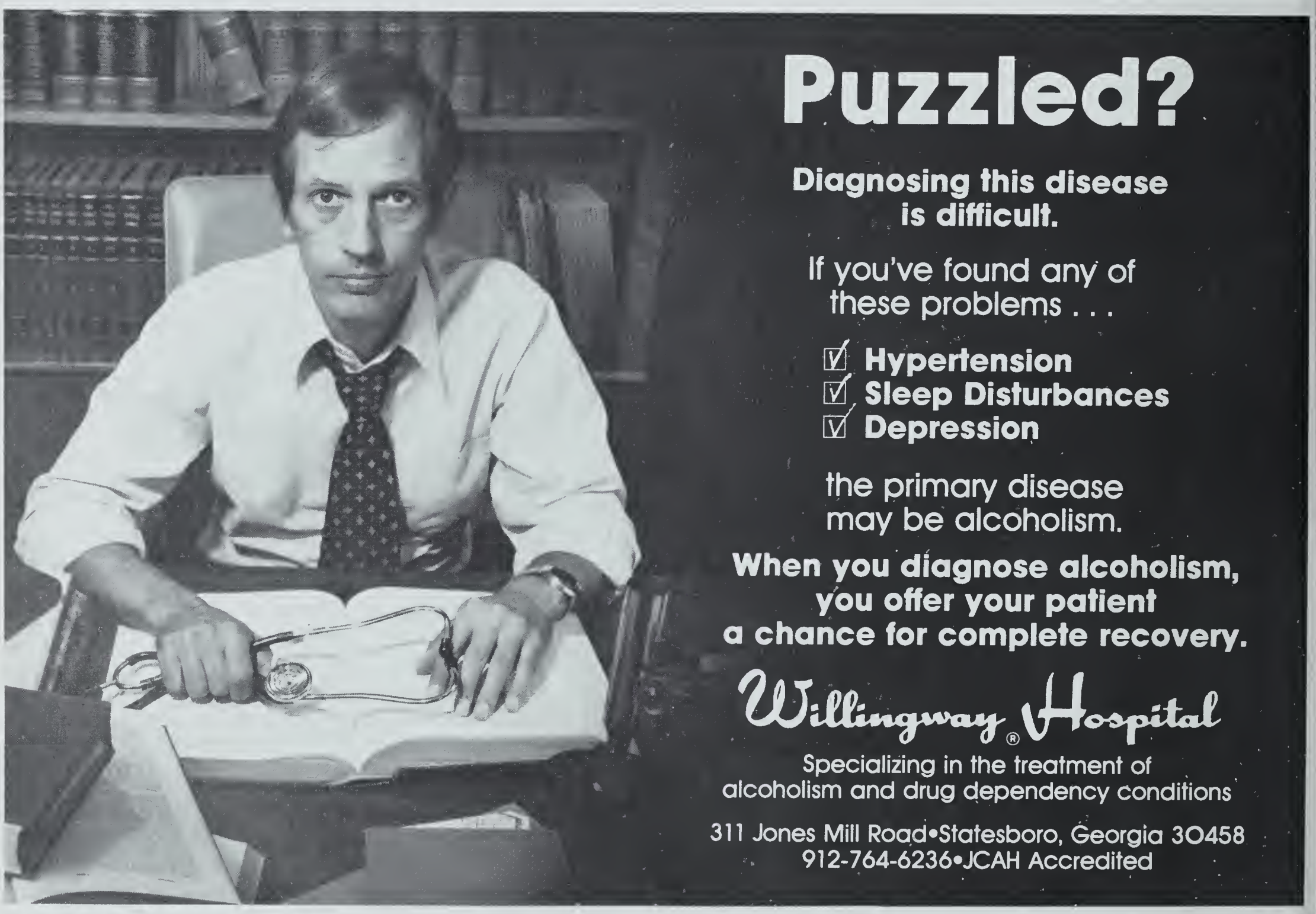
A music soars, tattered dancers spin;
A harp rings clear above the din.
Does the wren sing soft in a garden small?

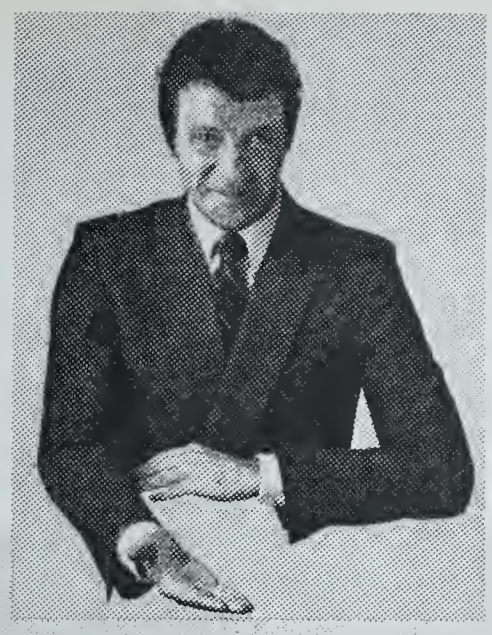
Information must have been available, for Flash jumped back in and we spun off through the slush again. "He was real suspicious, like they always are, til they see we're not the law. I tell 'em it's the doctor from the hospital, and they see the old meat-wagon here, and then they come across. It's the last place, three houses down on the left."

We slithered and bumped past two small houses, and then lurched along until the headlights picked up, through wet darkness, a solid wall of underbrush. Snake Road had quit. There was a sim suggestion of pine trees in the background, with their tops swaying and the wind soughing through them.

He fumbled with the switch on the handle of the spotlight. I said, "You know it never works. Turn around and see if the headlights show anything."

He shifted into reverse, muttering to himself. As we crawled around, wheels slipping and spinning, the lights picked up a house back in the trees. He snarled,





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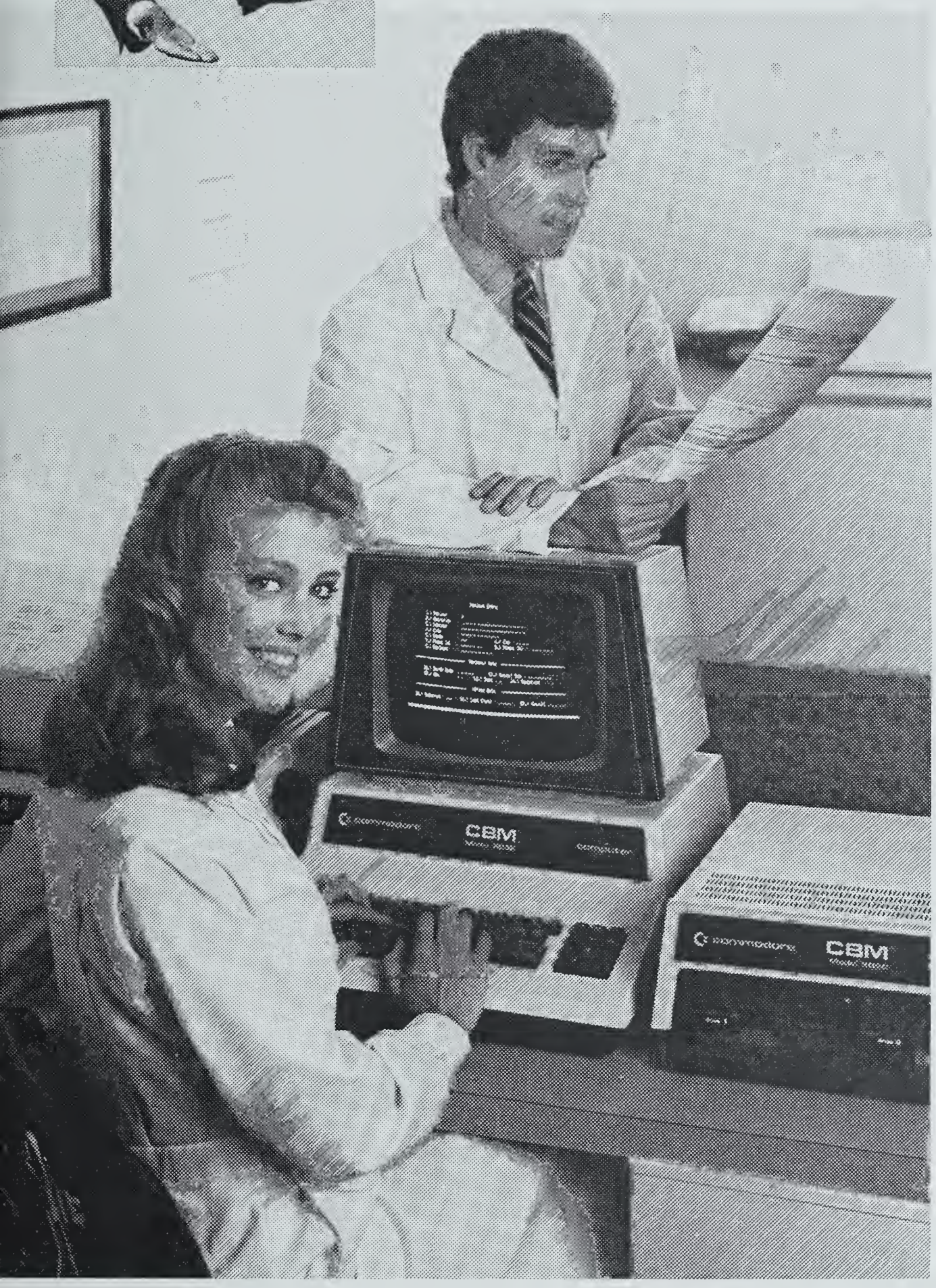

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"You're a real path-finder."

Then the question came to me. "Flash, if there's been a fight and somebody has called the hospital for help, why aren't the police here? They usually get places about when we arrive."

Withering wisdom answered, "Well, Doc, if you were smart you'd know how that is. Whoever called — wherever he called from, 'cause there ain't no phones down here — just was being sure he wasn't going to get into a mess. Nope, he wasn't going to stick around and direct traffic, and then get nailed himself. This is a quiet fight, kinda family-like — no big, loud neighborhood ruckus, with people running around and calling the law. You ain't been riding with me long enough to learn how these things go, Doc — you got lots to learn."

His explanation made sense; he was not naive about the machinations of people in violent trouble. "Now that we're here," I said, "shall we step out and see who's been cut up?"

He answered, smooth and quick, "You go up ahead, in the car lights, and I'll ease along, slow, and see if we can't get the wagon in closer to the house." Flash was not two jumps ahead of me this time. I knew he was thinking of carrying the cart, which he hated to do, and was trying to get the distance down to a minimum. Another trick he practiced regularly: the head end of a stretcher is, naturally, the heavier end; Flash would unobtrusively arrange that he was carrying the foot end.

"No," I said. "You can't get any closer, there's a ditch. Leave the lights on and the motor running — you know this thing won't start if you leave the lights on with the motor off, even for a little while. We'll both go and carry the stretcher."

He said, "It feels like that left rear wheel is getting flat. I'll go around and look at it while you're going in. I'll catch up with you in a minute."

"The damn wheel isn't flat, it's a hole, most likely. Get out and open the back. I'll shove the cart out from inside." I was beginning to wonder at this talk.

Flash pulled the door handle, then hesitated, "Say, you want to go back up the road a ways? There must be a phone somewhere we can use. I guess we ought to call the cops."

It was clear now. He was afraid to go into that dark little house, off in the dripping swamp — into that house where someone was bleeding badly, presumably from wounds received in a fight. Who knew, maybe the fight would resume, maybe a killer waited in the shadows, perhaps watching us even now — crazy drunk, peering through a crack in the door. Perfectly clear, too, that Flash had been two jumps ahead of me. And he was trying to fix it so that I'd be at least two yards ahead of him, going towards that house.

I began to chuckle. Flash exclaimed, "What's funny? I'm thinking of going for the cops, and you start laughing."

"I'm laughin at us. You and I, freezing in a rattle-trap ambulance at the end of a road in the rain, arguing with each other about who's scared the most." He looked at the mud.

I shoved the cart out the back doors and we dragged it across the ditch. There was a barely discernible path, now flowing with water, and I stumbled along, shoving aside brush, my feet squishing in sodden shoes. Closer to the house I saw a wan light through a window, a light that flickered, possibly from a fireplace. We stepped onto the porch and knocked loudly on the flimsy door. Nothing. I banged again. Nothing but the wind in the pines. Then Flash, the habitual door kicker, seized the knob, twisted, and pushed the door hard. It crashed open.

On the floor, her bare feet nearly touching the grate of the fireplace, sat a witch. She sat sideways to us, all hunched over, her scrawny arms drawn close to her sides, hands calm in her lap. In profile her face, obscured by the dimness of the room and the lank hair that fell around her neck, showed a nose and chin that almost met. She moved not a muscle, and stared unblinkingly at the fire as if transfixed. I was transfixed, to. Even Flash, the irrepressible, was wordless before this apparition. He recovered first, but not completely, as the softness of his whisper showed. "The phone call was right. Somebody was bleeding to death, and there she is, dead as a mackerel." Maybe he was kidding, but I wasn't sure, and I didn't think he was sure, either. I walked over, half expecting her to vanish up the chimney. "What's the matter here, Auntie?"

Only her head moved slowly. A hag's face turned towards me; tiny eyes in deep sockets peered unblinkingly. Abruptly, piercing, she screamed, "Sanctified Jesus!"

I took a deep breath and slightly firmer grip on my resolve, and was trying to fit words together when a low moan sifted through the darkness. This was a more familiar sound; it must come from someone more solid than this possibly ectoplasmic figure on the floor. Hesitating to see what suprises this cabin contained, I opened a door to another room. I was still shakey from that scream. This room smelled smokey and oily; my penlight picked up a kerosene lamp, with its bowl empty, sitting on a washstand. The spot of light traveled to a bed, on which in a pile of tumbled bed clothes lay a young woman. Whoever had placed that call to the hospital hadn't exaggerated, for that woman had been bleeding badly. The sheets and an old blanket were soaked; so were towels, as well as the woman's clothes. But there hadn't been a fight, and she hadn't been cut up. For there on the bed beside here, partly covered by a protective arm, was her new-born baby.

My breath, which I had held for at least five minutes, whistled out. I pulled aside the garments and felt her pulse; soft, thready, rapid. The baby jerked his leg and whimpered; he looked healthy. She rolled her head and said, "Thirsty."

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.[1]

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.[2]

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.[3]

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Flash, functioning superbly again asked, ''I guess we gotta carry her all the way to the wagon?''

We found some dry blankets, wrapped mother and child, and loaded them on the stretcher. As we stumbled through the other room I said to Auntie, who hand't moved an inch, ''We're taking her and the baby to the hospital.'' More dubiously, ''They're going to be all right.'' She didn't even scream. The rain had stopped, fortunately, and we got to the ambulance without spilling our patients. Sure enough, he outmaneuvered me again: I carried the head end.

During the ride back to the hospital she told me that she had been staying with her grandmother, and when the pains started she didn't know what to expect since this was her first child. A friend had dropped in to visit, became frightened when the bleeding started, and had left with a promise to call for help. After saying all that the patient was breathing heavily — another bad sign. I wondered if she would die before we could get to the hospital.

Flash took off his coat and handed it to be. ''Throw it over them,'' he growled. We both were soaked, of course, and shaking constantly. He took some small pleasure in scaring a few motorists, but drove without his usual wild elan. The siren blasted right up to the emergency entrance. The baby was all right. We gave mother to the obstetrical department. As we left her there, she looked at me, her fact sweat-splotched, breathing heavy, the dark skin somehow paler. ''What's your name, Doctor?''

Cold, hungry, I snapped, ''Dr. Brown.''

''No — what they call you — your given name?''

''Claude.''

I checked on her the next day; she and the baby were doing well. The episode was lost to me soon, absorbed in the swarm of other desperate patients.

Several weeks later Flash and I were walking to the ambulance entrance, and passed the door of the pediatric clinic. A young woman carrying a plump baby came up to us and asked, beaming, ''How you like this baby, Dr. Brown?''

Wondering how she knew my name, I said, ''He's real handsome.''

''Don't you remember, down on Snake Road, a month ago you came in the ambulance and got me. If I'd stayed there all night with Grandma I know we'd a-died, but we're all fine now.'' She smiled brightly. ''I named him Claude Brown Jones.''

Flash rubbed his thin jaw. ''Your first name-sake, Doc. You got a fat black baby, and you ain't even married.''

He parted the folds of the blanket and gazed thoughtfully at the placid infant. ''By God, he does have your features.'' ⊡

Pathogenesis of the Radiographic Air Crescent and Target Signs of Invasive Pulmonary Aspergillosis

Myung S. Shin, M.D.*
Kang-Jey Ho, M.D., Ph.D.†

Two cases of invasive pulmonary aspergillosis in immune-compromised patients manifested radiographically by air cresent and target signs were described. These signs were produced by central infarction due to vascular invasion by aspergillus hyphae and overinflation secondary to a check-value obstruction of the communicating bronchus. Their recognition is essential for early diagnosis and proper treatment of this life-threatening condition.

A pulmonary cavitary lesion containing solid tissue, partially or completely surrounded by air, should produce either an air crescent or a target sign on chest roentgenogram.[1-12] The air crescent or meniscus sign has long been recognized in pulmonary tuberculosis, Rasmussen aneurysm, echinococcal cyst, lung abscesses, bronchogenic carcinoma, adenoma, harmatoma, hematoma, sclerosing hemangioma and aspergillosis.[1-11] The target sign has only been recently described in five cases of suppurative lung disease secondary to septic embolism.[12] From our own experience both the air crescent sign and the target signs have the same pathogenetic process and can be observed in the same patients. Furthermore, these signs, although not pathognomonic, are most frequently seen in patients with pulmonary aspergillosis.[4, 9-11] Illustrated here are two cases of invasive pulmonary aspergillosis manifested radiographically with air crescent and target signs. These signs are correlated with the lesions found at autopsy in one case and by lung biopsy in the other. We stress that the early recognition of these radiographic signs and the definite etiologic diagnosis are essential for proper treatment of this life-threatening disease.

Case Reports

Case 1

A 30-year-old male was diagnosed as having acute myelogenous leukemia and underwent four courses of combined chemotherapy over a period of ten months. Shortly after the completion of the fourth course of chemotherapy he spiked fever and for the first time a right upper lobe pneumonia was noted on chest roentgenogram. Staphylococcus aureus was identified in a blood culture. In spite of antibiotic therapy the right upper lobe pneumonia progressed within a week to a large air-filled cavity containing a movable mass which moved according to the gravity as the patient changed position (Fig. 1). At the same time an area of consolidation with air-crescent sign appeared in the left lower lobe (Fig. 1). Fungus balls were clinically suspected. The brushing obtained at bronchoscopy, however, grew only Klebsiella pneumonia but no fungus. The lung lesions were continuously treated as bacterial pneumonia. While the wall of the cavities became somewhat thickened, new cavitary lesions puffed out one after the other on the subsequent chest roentgenograms. He developed agonal respiration and expired two weeks later.

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Address reprint requests to: Dr. M. S. Shin, Department of Diagnostic Radiology, University of Alabama School of Medicine, Birmingham, Alabama 35233.

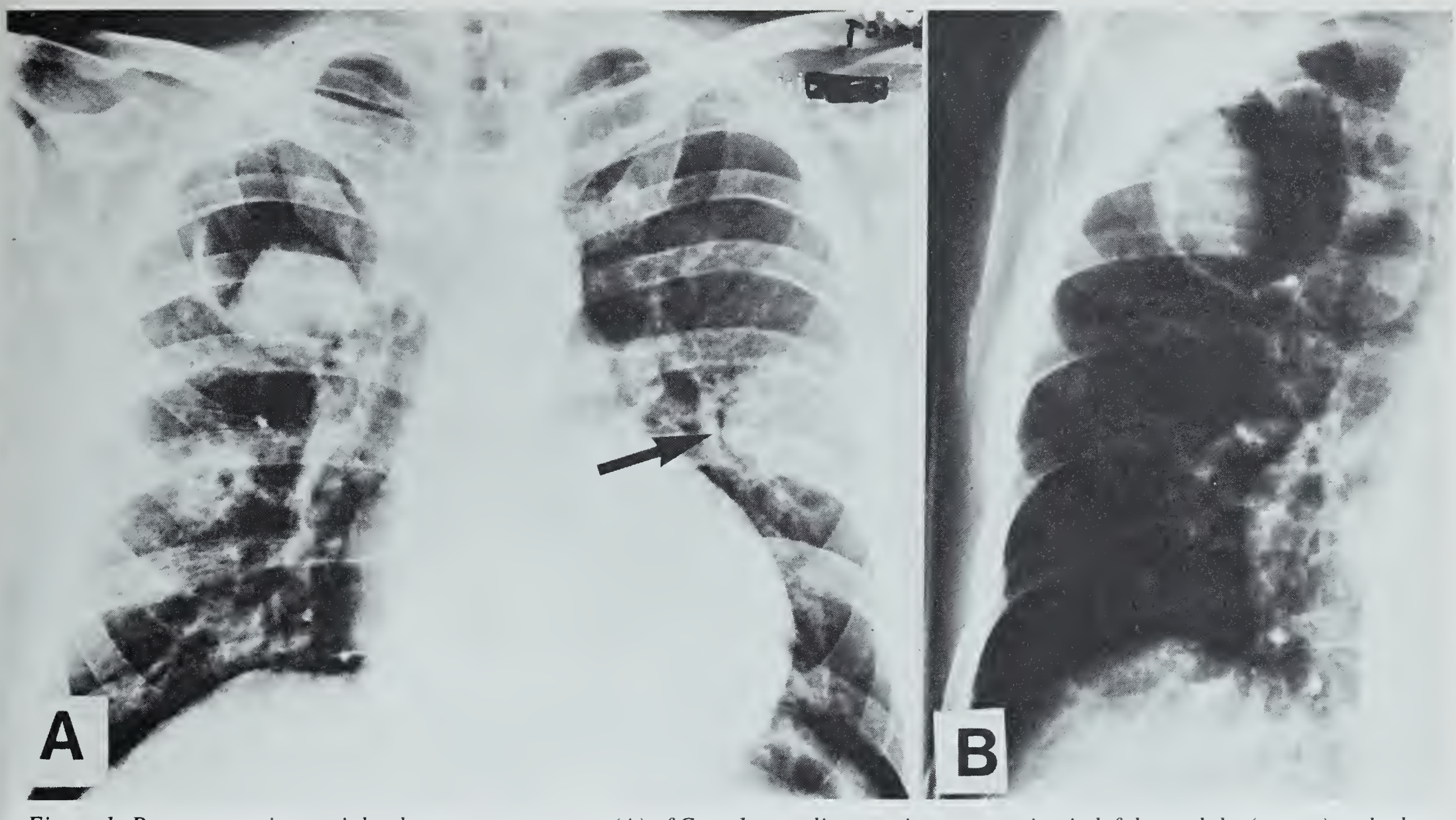

Figure 1. Posteroanterior upright chest roentgenogram (A) of Case 1 revealing an air crescent sign in left lower lobe (arrow) and a large round cavity in the right upper lobe which contains a movable solid mass as manifested by its gravity dependent position in right decubitus film (B).

At autopsy, multiple cavitary lesions were noted in both lungs. The large cavity in the right upper lobe measured 6 cm. in diameter (Fig. 2). The inner wall was irregularly thickened. The cavity communicated with a bronchus and somewhat collapsed upon opening. A dark brown mass measuring 4 cm. in its greatest dimension was suspended by two thin ''strings'' in the cavity. This movable mass was proven to be necrotic lung tissue infiltrated by viable septated hyphae, 3 to 4 μ in diameter, demonstrating 45 degree dichotomous branching (Fig. 3). Postmortem culture of lung tissue grew aspergillus fumigatus. The suspending ''strings'' were in fact arteries with organized thrombi. Invasive aspergillosis was evident in the wall of the cavity. Vascular invasion by the fungi was observed frequently (Fig. 4). A smaller cavitary lesion with radiographic air crescent sign is shown in Fig. 5. This cavity had a thick wall infiltrated by aspergillus hyphae associated with granulomatous reaction (Fig. 6) and a necrotic mass protruding from the wall to the cavity with fungi growing in it. Another similar cavity shown in Fig. 7 demonstrated the communication of the cavity with dilated bronchus.

Case 2

A 30-year-old woman developed fever, weight loss, upper respiratory infection, and paronychia over a period of two months prior to admission. Because of the failure of paronychia to respond to antibiotics, blood count was done which showed a white cell count of 30,000 with over 80% blasts. A bone marrow biopsy confirmed the diagnosis of acute undifferentiated leukemia. Culture of the paronychia grew staphylococcus aureus, Klebsiella pneumonia, and Echerchia coli. She continued to receive multiple antibiotics in addi-

Figure 2. The cavitary lung lesion in the right upper lobe of Case 1 showing a necrotic mass suspending in the cavity by two thrombosed arteries.

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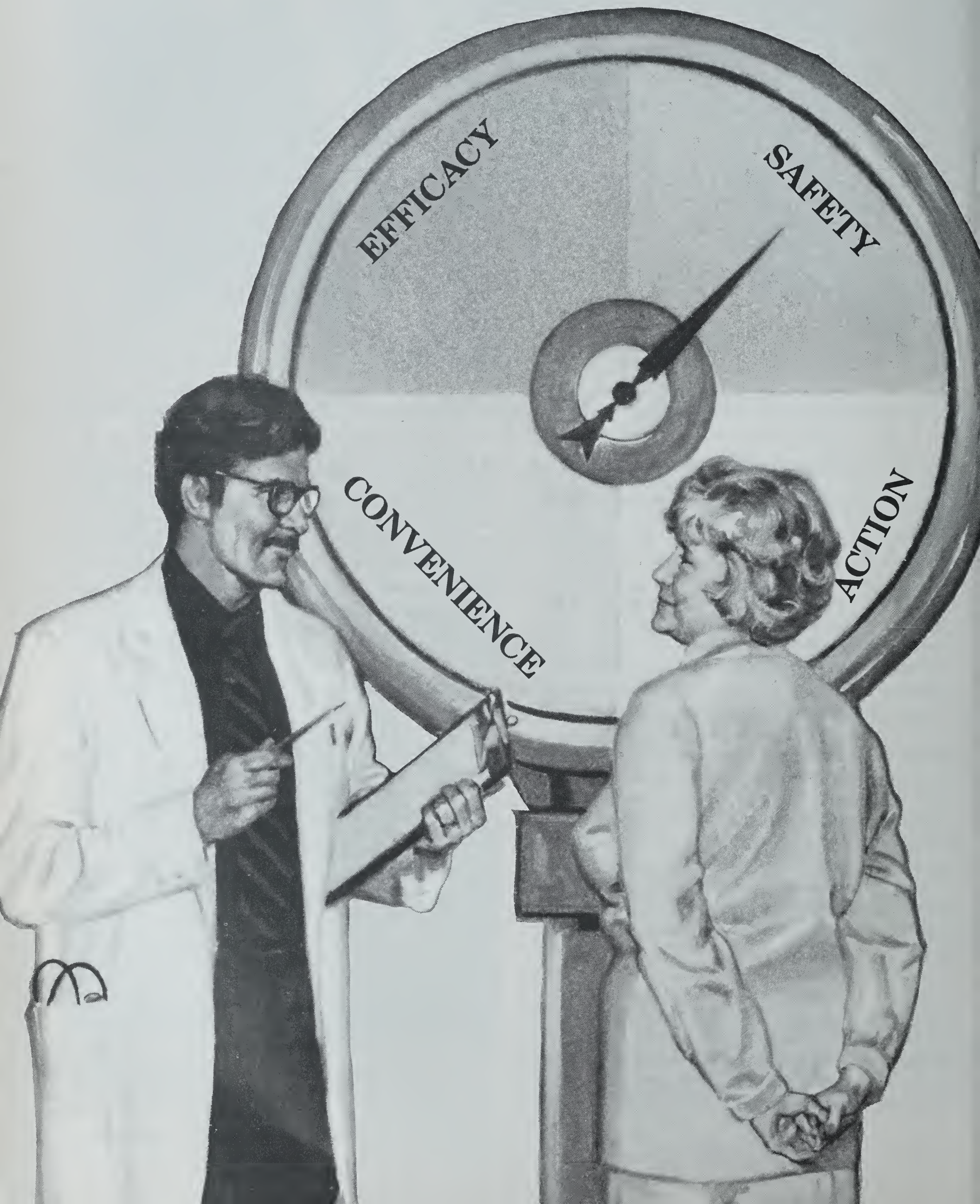

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Because MELFIAT 105 has a 3.7 hour half-life and low abuse potential.
Therapeutic efficacy combined with a short half-life and minimal abuse potential make MELFIAT 105 the drug of choice in the treatment of exogenous obesity. Because MELFIAT 105 has a short half-life, it minimizes drug accumulation and helps to eliminate such effects as disturbed sleep patterns. And, because MELFIAT 105 has significantly lower abuse potential than the amphetamines; there's less risk to your patients. According to a NIDA (National Institute on Drug Abuse) report, phendimetrazine appears to be the least abused anorexiant when compared to phentermine and diethylpropion.[1]

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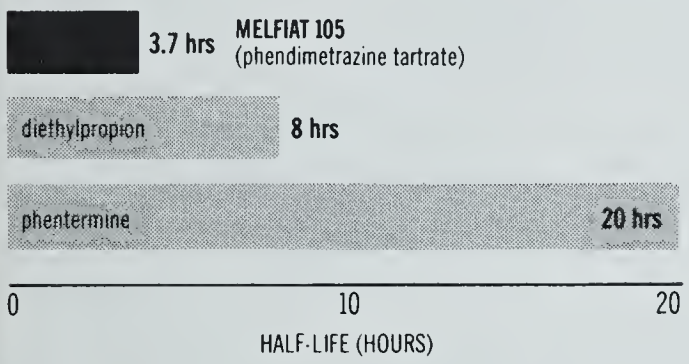

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MELFIAT® 105 UNICELLES® C III
(phendimetrazine tartrate) Sustained-Release Capsules 105 mg

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MELFIAT® 105 UNICELLES® C III
(phendimetrazine tartrate) 105 mg Sustained-Release Capsules

INDICATIONS AND USAGE: Melfiat® 105 (phendimetrazine tartrate) is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (See CLINICAL PHARMACOLOGY) should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

WARNINGS: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should be discontinued. Phendimetrazine tartrate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Phendimetrazine tartrate is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of phendimetrazine tartrate should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high-dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG, manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

USAGE IN PREGNANCY: The safety of phendimetrazine tartrate in pregnancy and lactation has not been established. Therefore, phendimetrazine tartrate should not be taken by women who are or may become pregnant.

USAGE IN CHILDREN: Phendimetrazine tartrate is not recommended for use in children under 12 years of age.

PRECAUTION: Caution is to be exercised in prescribing phendimetrazine tartrate for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of phendimetrazine tartrate and the concomitant dietary regimen. Phendimetrazine tartrate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure.
Central Nervous System: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses.
Gastrointestinal: Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
Allergic: Urticaria.
Endocrine: Impotence, changes in libido.

OVERDOSAGE: Manifestations of acute overdosage with phendimetrazine tartrate include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states.
Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma. Management of acute phendimetrazine tartrate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases phendimetrazine tartrate excretion. Intravenous phentolamine (Regitine) has been suggested for possible acute, severe hypertension, if this complicates phendimetrazine tartrate overdosage.

DOSAGE AND ADMINISTRATION: Since Melfiat® 105 (phendimetrazine tartrate) 105 mg is a sustained-release dosage form, limit to one sustained-release capsule in the morning. Melfiat® 105 (phendimetrazine tartrate) is not recommended for use in children under 12 years of age.

HOW SUPPLIED: Each orange and clear sustained-release capsule contains 105 mg phendimetrazine tartrate in bottles of 100.

CAUTION: Federal law prohibits dispensing without prescription.

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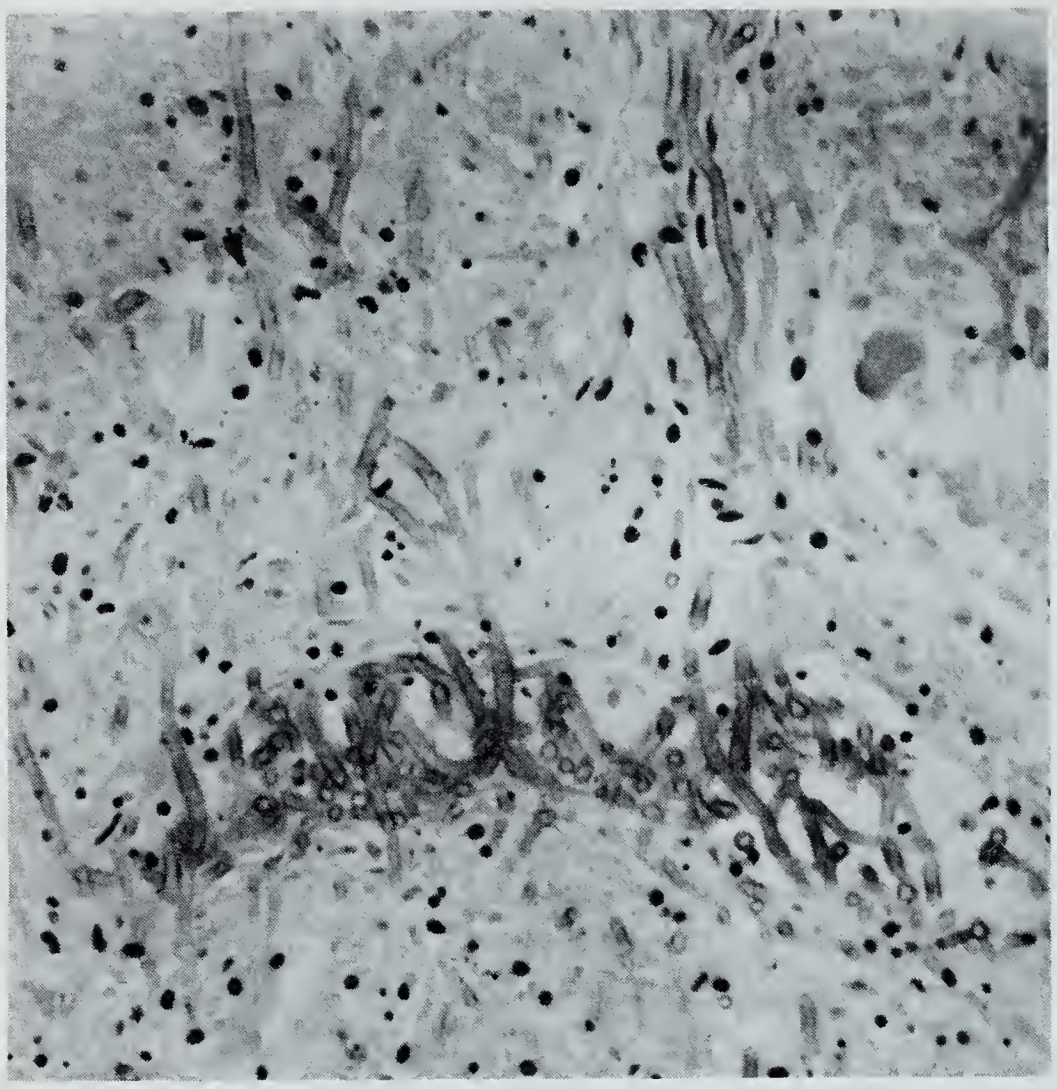

Figure 3. Aspergillus hyphae growing in the central necrotic tissue in the cavitary lesion of right upper lobe in Case 1 (Hematoxylin and eosin, original magnification × 300).

tion to chemotherapy for acute leukemia. The latter was discontinued in the fourth week of hospitalization because her peripheral white cell count dropped to 600 and bone marrow became extremely necrotic and hypoplastic. Meanwhile she developed intermittent fever with bilateral pulmonary opacities. Blood culture grew E. coli and Citrobacter species. Despite intensive antibiotic therapy and gradual recovery of the hematopoietic activity in bone marrow, the patchy areas of consolidation shown on chest roentgenogram progressed, over a period of one week, to well demarcated round lesions with either typical air crescent or target sign (Fig. 8). Right pneumothorax was also noted. The air crescent sign was also present in thoracic computed tomogram (Fig. 9). Repeated hemoptysis occurred and

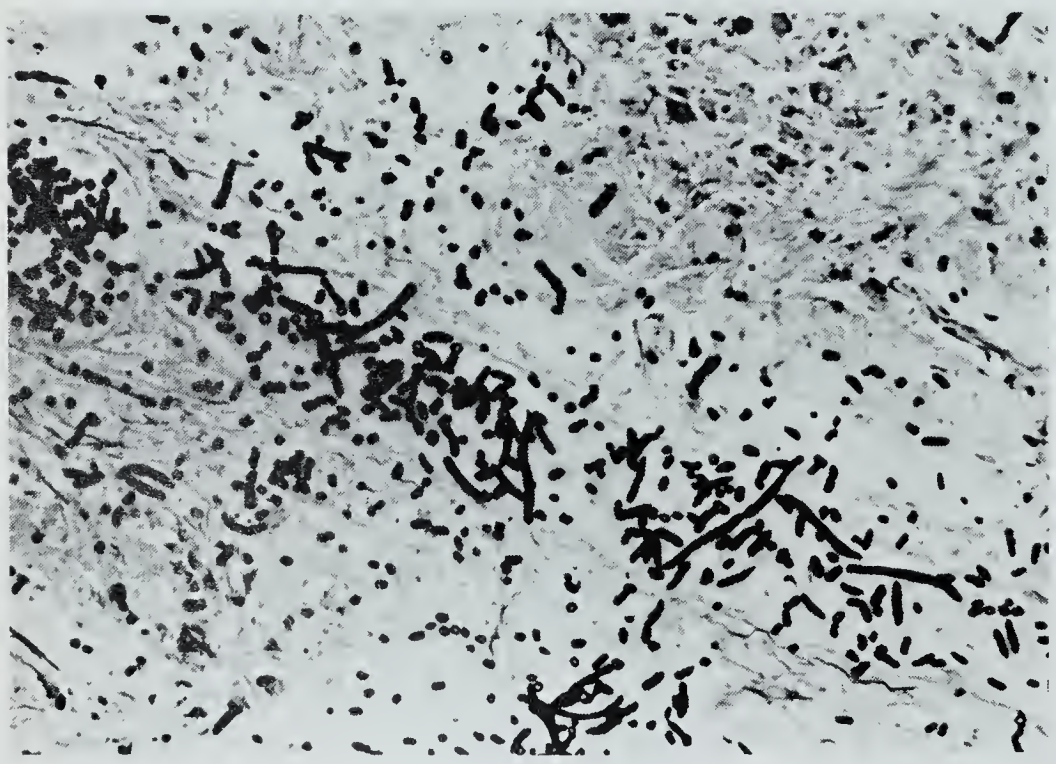

Figure 4. A vessel in the wall of right upper lobe cavitary lesion in Case 1 invaded by aspergillus hyphae. (Gomori's methenamine-silver nitrate, original magnification × 300).

sputum culture grew aspergillus flavus of questionable clinical significance.

A Hickman catheter within right subclavian vein for the proper intravenous hyperalimentation was thought to be the possible source of pulmonary septic embolism which was removed and proven to be sterile. Lung biopsy was then done under fiberoptic bronchoscopy which revealed aspergillus hyphae growing in both necrotic and viable lung parenchyma with granulomatous reaction similar to those shown in Fig. 3 and 6. Simultaneous tissue culture grew aspergillus flavus. The patient was treated with amphotericin B and 5-fluorocytosine without adverse side effects. Three days later fever was subsided, pneumothorax dissolved, and the respiratory symptoms were much improved.

Discussion

Aspergillus is unique among various species of fungi for its ''schizophrenic'' characteristics.[13] As a saprophyte it produces noninvasive aspergilloma or fungus balls in a preexisting lung cavity;[14] as an infectious

Figure 5. A smaller cavitary lung lesion in Case 1 with a central mass attaching to the wall. Such a lesion could produce either an air crescent sign or a target sign on chest roentgenogram depending upon the angle of the film taken.

It all adds up,

in today's major hypertension studies

VA Study[1]

- 450 patients studied
- Mild to moderate hypertensives
- Comparison of propranolol and reserpine for Step-2 antihypertensive therapy
- **Conclusion:** when added to a thiazide diuretic, reserpine was effective in a larger percentage of patients (88%) than was propranolol (81%)!

HDFP Study[2]

- More than 10,000 patients studied
- Conducted at 14 centers over 5 years
- Proved that compliance with Step Care lowers death rate from all cardiovascular causes
- **Conclusion:** reserpine-thiazide regimens were *preferred* for Step-2 therapy, and were deemed effective, without significant adverse effects!

MRFIT Study[3]

- 6-year, 12,000-patient study, to be completed in 1982
- Assesses factors that may increase risk of cardiovascular disease
- Preferred Step-2 regimen: reserpine-thiazide
- **Full year's data:** reserpine is causing less depression than methyldopa, diuretics, or placebo!

That's why the combination in

Salutensin®

(hydroflumethiazide 50 mg/ reserpine 0.125 mg)

Is the preferred Step-2 regimen

Please see references and brief summary of prescribing information on adjacent page.

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Salutensin®
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Salutensin-Demi™
(hydroflumethiazide 25 mg/reserpine 0.125 mg)
Brief Summary of Prescribing Information (12) 10/27/78
For complete information consult Official Package Circular.

WARNING

This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS

Anuria, oliguria, active peptic ulceration, ulcerative colitis, severe depression or hypersensitivity to its components contraindicates the use of Salutensin.

WARNINGS

Small-bowel lesions (obstruction, hemorrhage, perforation and death) have occurred during therapy with enteric-coated formulations containing potassium, with or without thiazides. Such potassium formulations should be used with Salutensin only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs. Use cautiously, and only when deemed essential, in fertile, pregnant or lactating patients.

Use in Pregnancy—Thiazides cross the placenta and can cause fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly electrolyte disturbances. Fatal reactions may occur with reserpine during electroshock therapy; discontinue Salutensin 2 weeks before such therapy. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.

PRECAUTIONS

Azotemia, hypochloremia, hyponatremia, hypochloremic alkalosis and hypokalemia (especially with hepatic cirrhosis and corticosteroid therapy) may occur, particularly with pre-existing vomiting and diarrhea. Potassium loss may cause digitalis intoxication. *Potassium loss responds to potassium-rich foods, potassium chloride or, if necessary, discontinuation of therapy.* Serum ammonia elevation may precipitate coma in precomatose hepatic cirrhotics. Discontinue therapy 2 weeks before surgery or if myocardial irritability, progressive azotemia or severe depression occur. Exercise caution in patients with chronic uremia, angina pectoris, coronary thrombosis or extensive cerebral vascular disease or bronchial asthma and in those with a history of peptic ulceration or bronchial asthma; in post-sympathectomy patients; in patients on quinidine; and in patients with gallstones, in whom biliary colic may occur. Patients who have diabetes mellitus or who are suspected of being prediabetic should be kept under close observation if treated with this agent.

ADVERSE REACTIONS

Hydroflumethiazide—Skin-rashes (including exfoliative dermatitis), skin photosensitivity, urticaria, necrotizing angiitis, xanthopsia, granulocytopenia, aplastic anemia, orthostatic hypotension (potentiated with alcohol, barbiturates or narcotics), allergic glomerulonephritis, acute pancreatitis, liver involvement (intrahepatic cholestatic jaundice), purpura plus or minus thrombocytopenia, hyperuricemia, hyperglycemia, glycosuria, malaise, weakness, dizziness, fatigue, paresthesias, muscle cramps, skin rash, epigastric distress, vomiting, diarrhea and constipation.

Reserpine—Depression, peptic ulceration, diarrhea, Parkinsonism, nasal stuffiness, dryness of the mouth, weight gain, impotence or decreased libido, conjunctival injection, dull sensorium, deafness, glaucoma, uveitis, optic atrophy, and, with overdosage, agitation, insomnia and nightmares.

USUAL DOSE

The usual adult dose of Salutensin is one tablet once or twice daily. If a smaller amount of thiazide diuretic is desired, Salutensin-Demi, one tablet once or twice daily can be given.

SUPPLIED

Bottles of 10 and 1000 scored tablets.

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agent it creates invasive pulmonary aspergillosis,[15] and as a potent allergen it induces extrinsic asthma mediated by IgE,[16] extrinsic allergic alveolitis mediated by IgG,[13] and allergic bronchopulmonary aspergillosis through both IgE and IgG.[17] Invasive aspergillosis occurs most commonly in patients rendered neutropenia by cancer chemotherapy, particularly in patients with acute leukemia because of the profound myelosuppression[13] as demonstrated in our two cases.

The onset of invasive pulmonary aspergillosis in immune compromised patients is usually dramatic mimicking of acute bacterial pneumonia and almost always treated as such because blood and sputum cultures are rarely positive for the aspergillus species.[13] Even a positive culture may be questionable for a contaminant for aspergillus species are ubiquitous organisms. The present cases emphasize that the rapidity of development of cavitary lung lesions from initial patchy bronchopneumonia in immune-compromised patients. Death may occur within a week or two if not properly treated.

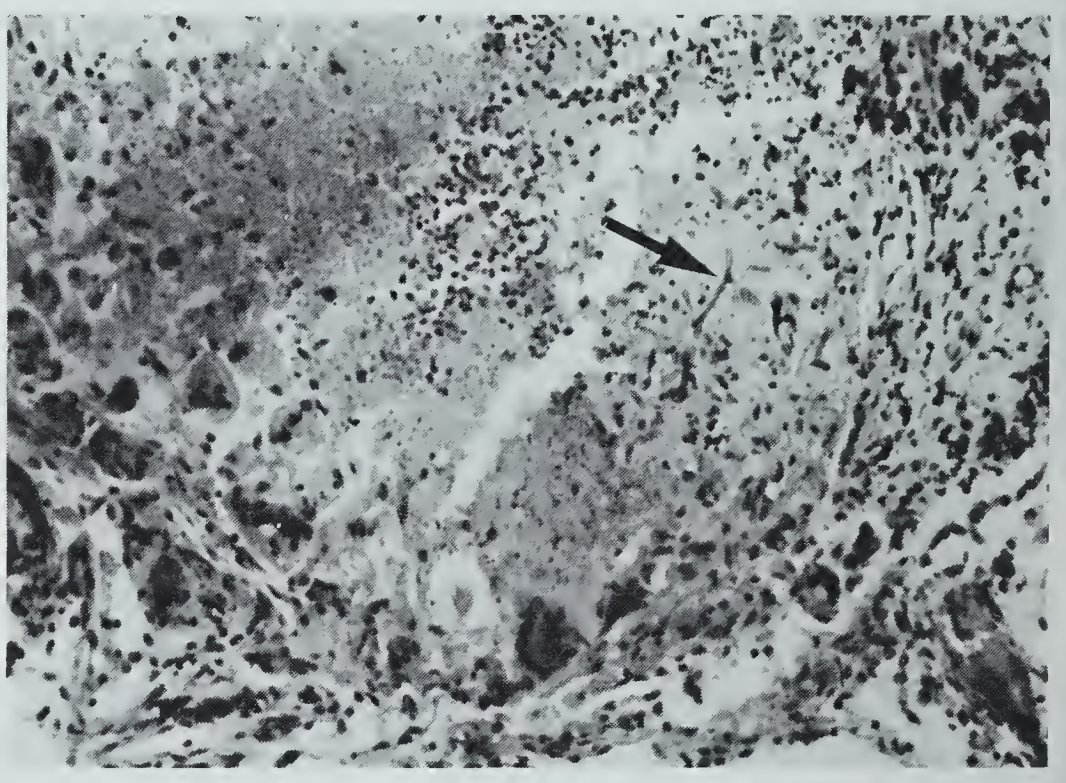

Figure 6. The wall of the cavitary lesion in Fig. 5 revealing granulomatous and necrotizing inflammation reacting to the invading hyphae (arrow).

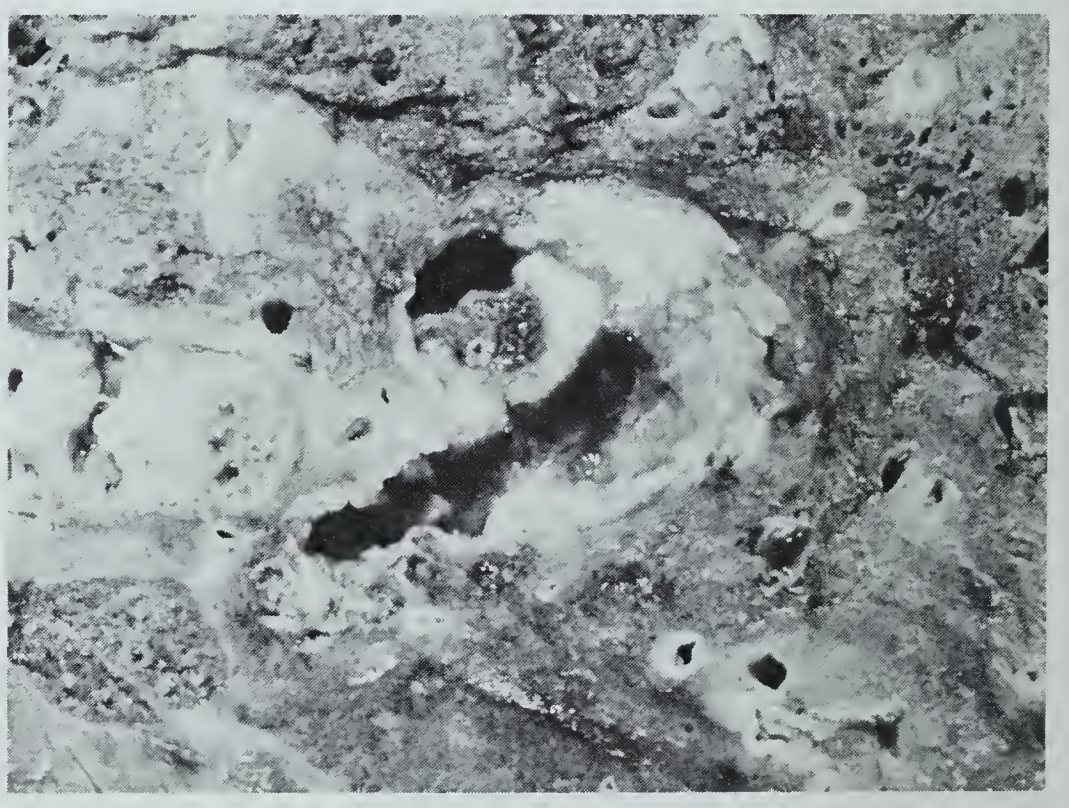

Figure 7. Another cavitary lesion in Case 1 demonstrating the communication of the cavity with a small bronchus.

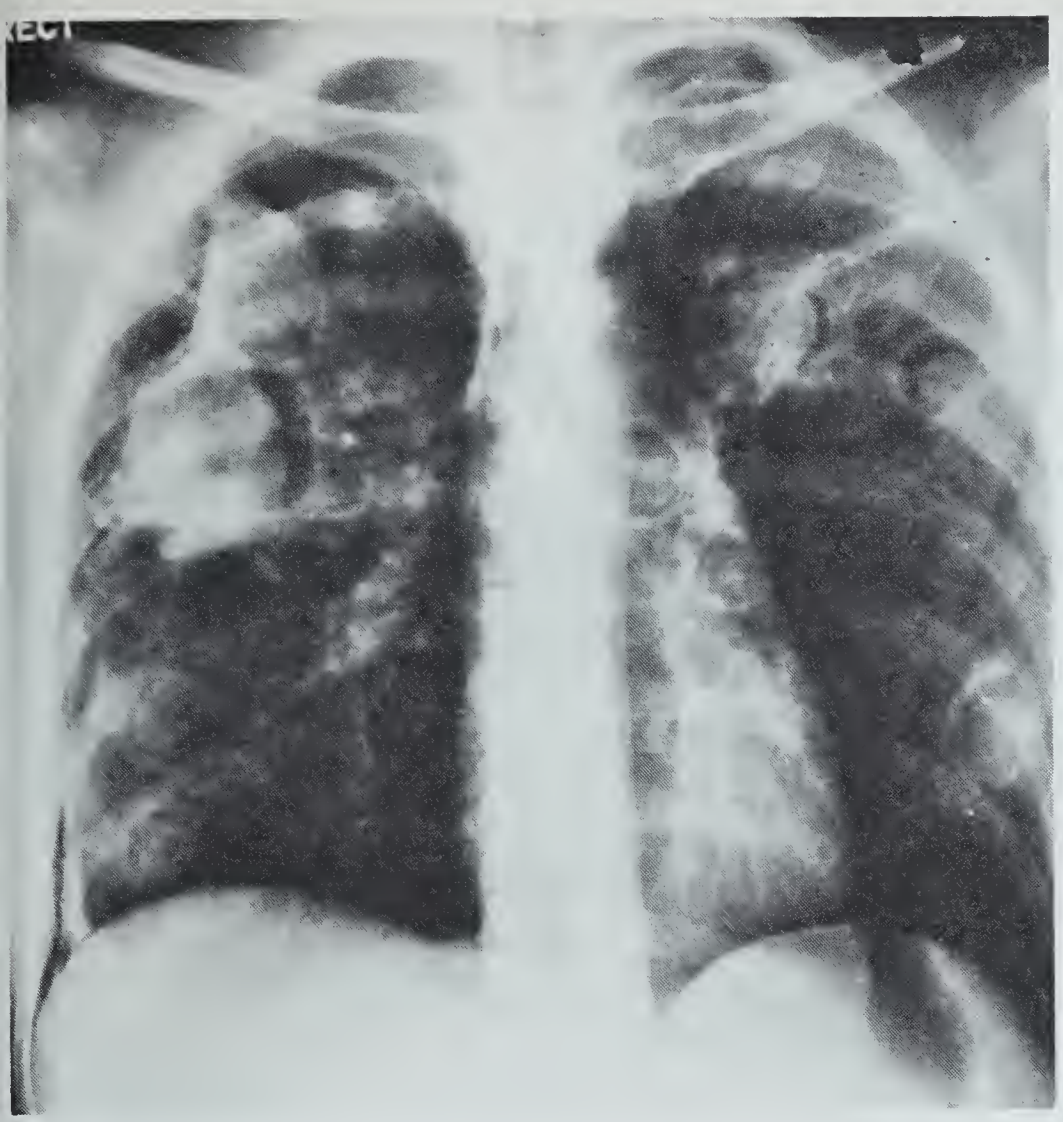

Figure 8. Multiple cavitary lesions with either air crescent sign or target sign on chest roentgenogram in Case 2.

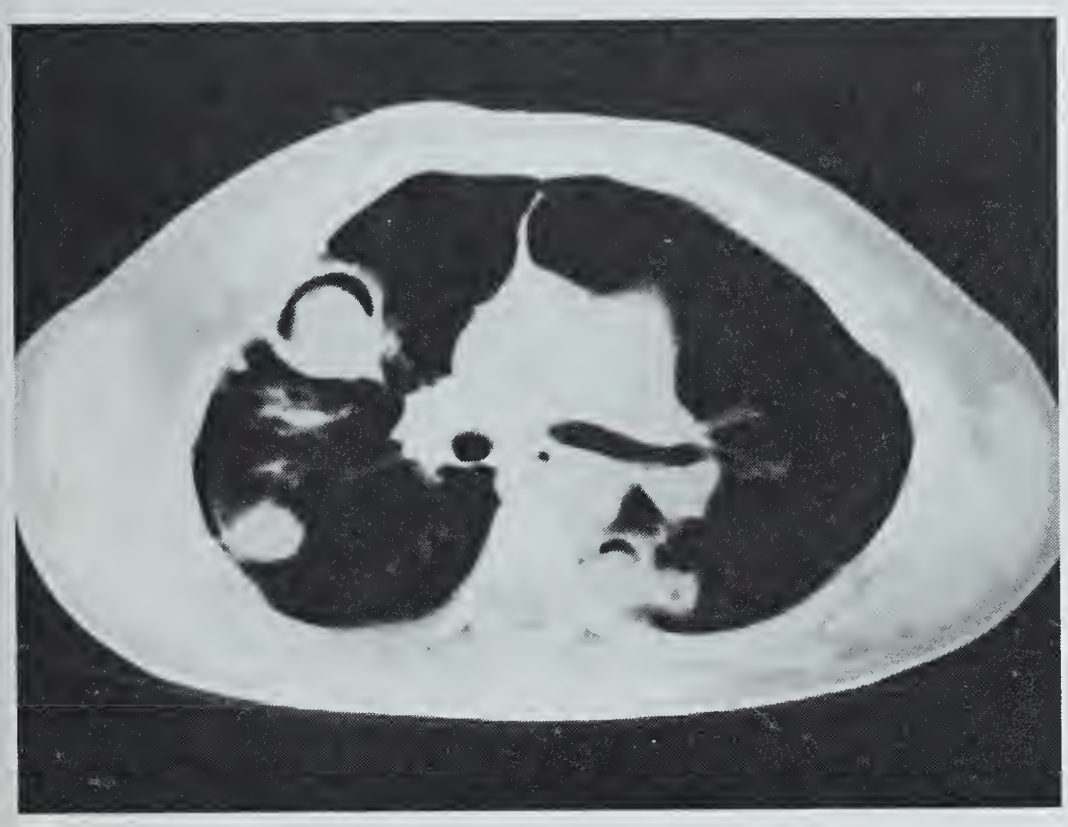

Figure 9. Thoracic computed tomogram of Case 2 showing cavitary lung lesions with typical air crescent sign.

The radiographic air crescent and target signs, though not specific, should alert one to the strong possibility of invasive pulmonary aspergillosis, particularly in those compromised patients. We have learned from the present cases that both air crescent and target signs are corresponding to the unique cavitary lung lesions produced by the same pathological process. The key to its pathogenesis is that the hyphae of aspergillus have a decided tendency to invade the blood vessels, producing thrombotic angiitis which in turn leads to either ischemic or hemorrhagic infarction of the lung parenchyma. Aspergillus hyphae apparently not only survive but also grow in the infarcted or necrotic tissue. Another key is the communication of a branch of bronchus or bronchioli to the lesion which is responsible for hyperinflation of the necrotic cavity essential for the production of air crescent or target lesions. The necrotic mass in the cavity may cause a check-valve obstruction of a communicating bronchus resulting in progressive hyperinflation of the cavity or formation of a pneumatocele.[12] The relative amount of air and the relative position of the necrotic mass in the cavity determine whether an air crescent sign or a target sign is seen roentgenographically. The necrotic tissue is usually heavily infiltrated by hyphae, attaches to the wall of cavity and has only a limited mobility. In extreme cases such as Case 1, the necrotic mass seems to move freely in the cavity because it is suspended loosely by two thrombosed arteries, masquerading as a fungus ball.

Radiographically the aspergilloma is classically described as a ''bell-like image'' with the fungus ball appearing as a clapper inside a bell.[13] The fungus ball is usually free within the cavity and moves as the patient changes position. Although hemoptysis can also be observed in patients with aspergilloma,[18] fungus ball is considered as benign and noninvasive, and should be distinguished from invasive pulmonary aspergillosis with a central necrotic mass. The distinction is usually made with no difficulty if one takes the clinical course into account. It is our contention that, however, the necrotic tissue infiltrated by aspergillus hyphae in the cavitary lesion of invasive pulmonary aspergillosis could be converted into a true fungus ball if the disease process is controlled by antifungal therapy and restoration of the host defense mechanism. Increasing evidence indicates that some aspergillomas may be, in fact, initiated by a subacute suppurative process.[19]

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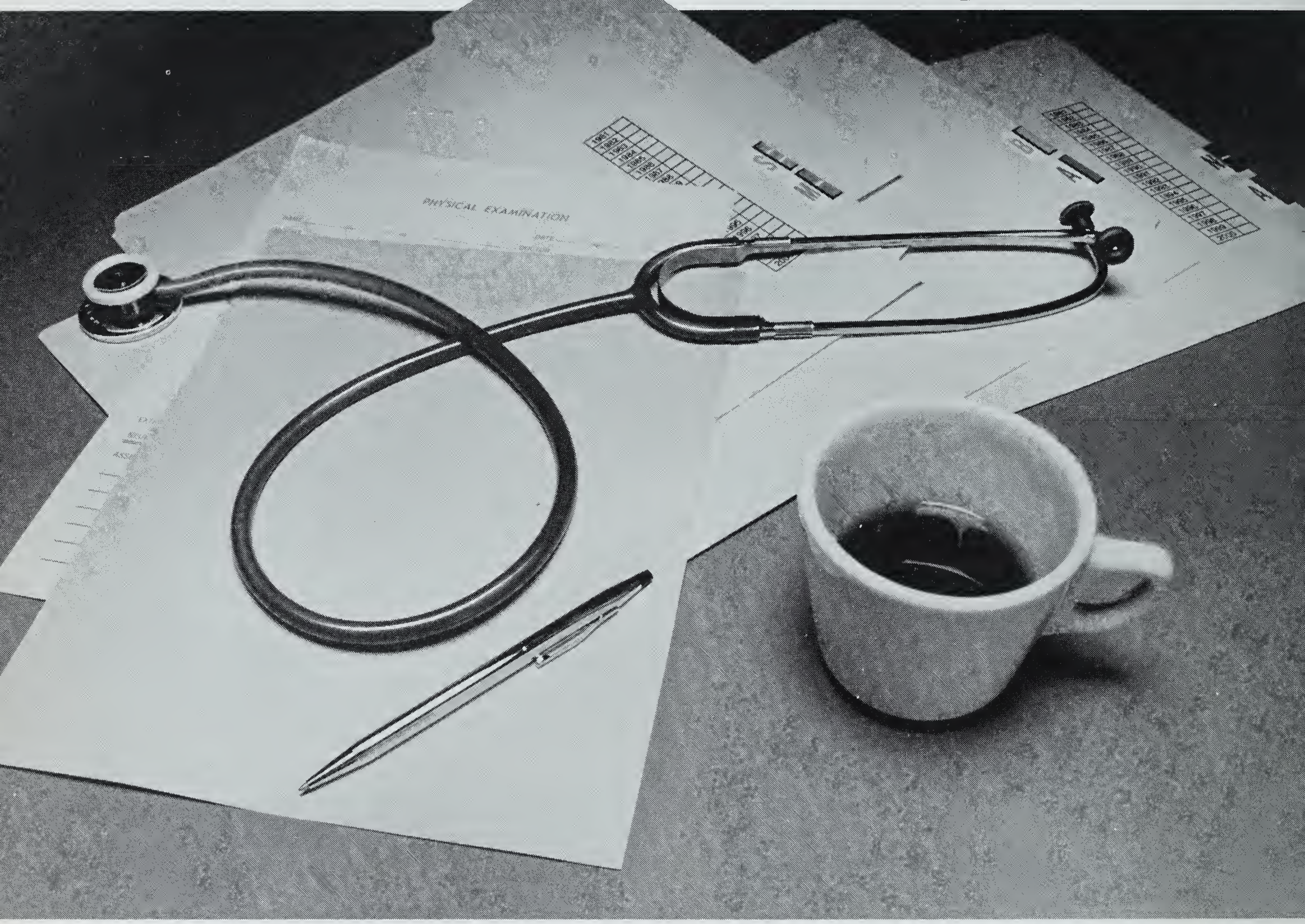

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Myths About Women: Medicine's Nostalgic View

Michele Wilson, Ph.D.*
Marilyn Raney, M.A.†
Linda E. Norton, M.D.‡

Introduction

A commitment to the view that the facts speak for themselves, and that one is a passive (and objective) observer is known in philosophy as crude empiricism.[1] A person thus committed believes that all "facts" are readily apparent and interpreted by all right thinking persons in the same manner. However, what is not normally understood is that "facts" must be interpreted and most often on the basis of a traditional, conventional, and therefore subjective view.

There are a number of ways one can compare their views of reality to readily as it exists objectively. One would be to look for cross-cultural or regional variations. Second, does it hold true over time (historically)? Third, one can look at evidence systematically drawn according to scientific methodology.

Physicians are as likely as other members of society to hold beliefs, stereotypes and other subjective views not grounded in data but in uncritical "facts." Analyses of physicians as a subgroup of society, in fact, show they tend to be conservative, traditional, and supportive of patriarchy.[2] Because physicians are occupants of prestigeful, powerful, and authoritative positions, they can influence the beliefs and actions of others.[3] This is apparent in physicians' views of sex roles — a social phenomenon.[4, 5, 6]

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† Comprehensive Cancer Center, University of Alabama in Birmingham.
‡ Associate Professor of Pathology, University of Alabama in Birmingham.

Medicine's View of Women: Obstetrical/Gynecological

Sociologists differentiate between disease and sickness. The former denotes the biological state of unhealthiness and the latter is embodied in the concept of the sick role.[7] To be sick, or defined by others as sick is an atypical social state considered both undesirable and deviant. The professional's definition of the condition and decisions about its management are the crucial elements in the occurrence and nature of the sick role.[8] There has been an overlap in the concept of the sick role and images of the everyday functions of women; thus, pregnancy, menopause, and menstruation have been the basis for "female invalidism," or a reason to treat them as sick.[9, 10] In the past, and even today, many members of society — women and physicians included — believe that because of defective or inferior biology, likelihood of damage to the womb, raging hormones, and discomforts of menstruation, women are incapable of entering certain professions, pursuing serious mental endeavors, and are in constant need of medical monitoring, if not help all their lives. This belief, originating in medicine, that a woman's entire body and personality are dependent upon her reproductive organs is not one to easily die.

Gynecology texts have exhibited a consistent bias toward concern for the needs of the patients's husbands, and depict women's destiny to reproduce, nurture and serve. Section on sexual functioning do not

incorporate recent findings (e.g., Masters and Johnson), but a Victorian stereotype of procreation as the major function of sex.[11] A perusal of the more recent texts still show assumptions that the normal state for women is married and (eventually) with children. Female patients are preferred to be passive, uninformed, and are treated as children.[12]

Gynecologists, unlike most other medical specialists, usually see their patients when they are well. Yet the medical profession is cure oriented. What results is a tendency to define women as less than fully healthy. It has been found that: ''when sex is introduced as a variable in the analysis of the sick role as a deviant role, we see that female patients are compounded deviants — they are defined as ill by virtue of their reproductive functions; they are also held responsible for whatever is disabling, difficult to manage, or disruptive about these functions; and finally they are blamed for reacting emotionally to their physical condition.''[13]

It is not surprising that women who do not fit the image of weak and/or passive are frequently referred to psychiatrists by their gynecologists.[14]

Medicine's View of Women: Psychiatric

The most common distribution of phenomenon is the normal curve, and the most common pattern of group differences is that of overlapping normal curves. The averages and ranges of each group may be different but usually the within group variation is greater than the between group differences. Without this kind of understanding, one might assume that great differences exist between groups and stereotyping can result.

Clinicians, when asked to describe a healthy adult, a healthy male, and a healthy female, described a healthy adult and a healthy male in very similar terms. However, their description of a healthy female was more submissive, more dependent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crisis, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective, and disliking math and science.[15] That mental health clinicians hold such an unattractive opinion of women, which does not coincide with their ideal of a healthy adult, is to ignore overlapping characteristics of both men and women. In fact, it has been found that in blind situations, where the clinician does not know the characteristics of a respondent, he/she cannot identify their sex on the basis of standard diagnostic tests or transcribed interviews. Even the possibility of gross differences, such as between the ''sane'' and ''insane,'' cannot always be detected, and that diagnosis may be a consequence of the process of labeling.[16]

Psychiatry has derived most of its theory (misnamed) from the clinical setting, with its focus on etiology rather than epidemiology. The theoretical foundations laid by Freud and others were not based upon scientific methodology, nor upon what denotes a deviation from ''normal'' populations. The conclusions on what is ''normal'' or ''abnormal'' about women is based more on subjective interpretation than true distributions.

Basically, there has been found to be such a wide variety of personality traits, roles, and proper place for both women and men cross culturally, that psychological characteristics, social traits and roles, are not inevitable, immutable or based on innate biological differences.[17, 18] Our society expects women to be ''inconsistent, emotionally unstable, lacking in strong conscience or super-ego, weaker, 'nurturant' rather than productive, 'intuitive' rather than intelligent, and if they are at all 'normal,' suited to the home and the family. In short, the list adds up to a typical minority group stereotype of inferiority: if they know their place, which is the home, they are really quite lovable, happy, childlike, loving creatures.''[19]

Actually, few differences between males and females appear at birth: personality differences, such as dependence show at an early age, and intellectual differences appear at adolescence.[20] A logical explanation is the socialization process, where children are treated differently according to the expectations of the socializing agents.[21] Psychiatrists, like other members of society, hold expectations of what constitutes the stereotype of male and female behavior. They bring these expectations into the clinical setting, and they make clinical judgements which are affected by the social. Because psychiatrists are gatekeepers of the mental health system — definers and supervisors — it can be assumed that their views of women and mental health would predominate in the field of medicine. That their views are characterized by stereotypes, and traditionalism, confusion of ''ought'' with ''is,'' and selective perception[22] does not serve the alleged function of psychiatry: fulfilling one's potential as a human.

Medicine's View of Women: Social

The social view of women — that of roles and the attendant expectations of acceptable behavior and attitudes — is an area where one may confuse a distorted perception or dislike for a certain state of affairs with

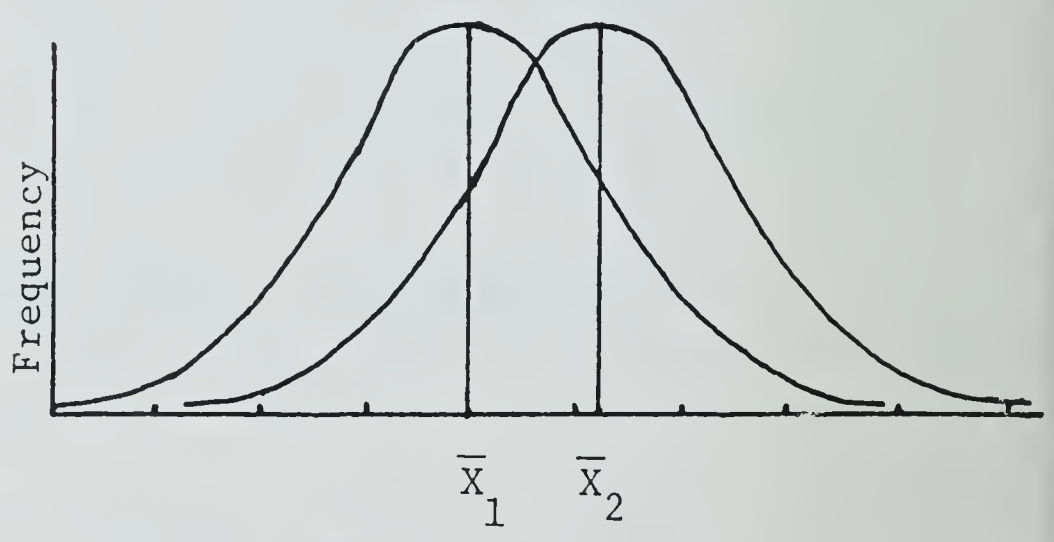

Figure 1. Illustrative example of ''between'' vs. ''within'' group variation.

the inevitable reality. One may check one's view of reality with data systematically drawn on populations, sub-populations and samples, such as U.S. Census Data, Health and Vital Statistics, and other similar data. These sources represent one's own time period, culture, and geographic location. One can look at rates and trends and with some certainty expect them to reflect social conditions. There are several trends in the life styles of women today which may contradict the general stereotype so strongly embraced by the medical profession. Overall, the medical and psychiatric view of adult women is that they are members of a family which approximates a *Saturday Evening Post* cover by Norman Rockwell. This nostalgic view of the family does not correspond to the data on the roles women assume today.[23]

A significant number of young adult women are not wives. One trend has been a slight postponement in age of first marriage for women. Another is that some of these women have "chosen" to be single mothers and thus are not in the position to assume the traditional roles. The increased divorce rate has resulted in many female-headed households.

More women are spending a good portion of their adult lives outside of the maternal role. There is a general decline in the birth rate. This is combined with a smaller but growing trend toward first births at older ages.[26, 27] The upshot is that the years of childbearing and rearing small children is over by the time most women are thirty-six. Ahead are about forty years where the maternal role is phased out.

Economic reality and personal need have resulted in the average woman being in the paid labor force in addition to her home responsibilities. Currently, women constitute about 43 percent of the labor force with about 55 percent of the female population over sixteen years of age working out of the home. The most significant number of women workers are in the 25 to 34 age group — those in the traditional "child rearing" years. Marital status does affect labor force participation: widowed women are least likely to work, followed by married with husband present, separated, divorced, and finally, single women have the highest rates. Over time, married women have dramatically increased their direct participation in the labor force. In addition, over 57 percent of married mothers with children aged 6-17 are in the labor force. Over 40 percent of married mothers of children under age 6 work outside the home.[28]

Conclusion

The family of western nostalgia — father working out of the home, mother working in the home fulltime, and with young children — is atypical in our society. In fact, less than 15 percent of American families fit that model. That families do not fit the nostalgic model does not mean they are "pathological" rather, they are normal in the statistical, social and psychological sense. This empirically based social "reality" of women's lives appears to be one which the medical profession has generally not accepted as reality. If it is true that women are childlike, dependent on men, suited only to roles of wife, mother and homemaker, why then do so many women appear deviant? The answer is that they are indeed not deviant, but the stereotypical beliefs embraced by much of the medical profession deviates from the reality of most women's lives. Physicians need to be more knowledgeable about women's role in society rather than assume or superimpose an outdated view. Physicians as "caretakers," parent figures, spokepersons in their community, and writers of disseminated knowledge, must develop different, more realistic understandings of women: physicians can lead the way in expressing the social reality of women's lives rather than the nostalgic stereotype.

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Charles Henderson — A Man Stands Tall

Robert K. Wilson, Jr., M.D.*

A goodly number of people have urged me to submit a scholarly article on the Charles Henderson Child Health Center here in Troy, Alabama. "Scholarly articles," or at least scientific ones, require lengthy bibliographies so I began to feverishly digest articles dealing with such subjects as "Why a Doctor Chooses to Practice in a Rural Area" or "Unfulfilled in Podunk." You'd be surprised (perhaps you wouldn't) at the number of articles that are essentially raw statistics — data that tell which folks have what diseases and where they live.

Needless to say, I kept putting off this rather unpleasant task until finally, I just said to myself, "Self, why don't you just 'tell it like it is' — don't worry about bibliographies, but make this article more of an essay or a sermonette." So a dutiful task rather quickly became, instead, a gratifying experience.

It might be well for us to consider three concepts which we'll tackle separately as we go along. The first concept is embodied in the old saying, "You can't take it with you." The second is captured in the motto that goes something like this: "No man stands taller than one who stoops to help a crippled child." The third is personified in the words of an old hymn entitled, "Will There Be Any Stars In My Crown?"

For any of you readers who come from Troy or Pike County or a neighboring county, you must forgive the presumption of a newcomer (to the area) in giving a brief biography of Charles Henderson, but it is quite necessary in order to fully explain how the Child Health Center came to be.

Charles Henderson was born in 1860 and began to put his incredible sixth sense (as related to business) to work at age 17. He was most industrious, shrewd and discerning as well as honest, trustworthy and uncommonly kind. Some of his major accomplishments included being governor of Alabama (1915-1919), founder of Troy Bank and Trust Company, Pea River Power Company, and the institution now called Troy State University. Additionally, he dealt with much land and the products therefrom and in the course of time, became quite wealthy. Though childless, he had a special love for children — this love most obviously acted out in his last will and testament. Love, my friends, is something you *do*.

Governor Henderson died in 1937, only a few months away from his 77th birthday. He made provisions in his will for his wife, who outlived him by three years, as well as certain family members. The bulk of his estate was put in trust at Troy Bank and Trust Company and for 20 years, according to his wishes, accumulated interest and thereby enlarged the corpus of the trust.

For the next 20 years (1957-1977), the interest from the trust went to "education" (building of schools in Pike County, improving facilities at existing sites,

* Medical Director of the Charles Henderson Child Health Center, Troy, Ala.

establishing scholarships and the like). Thereafter, to begin in 1977, the interest was designated to go to child health care. Because the original will had urged the building of a crippled children's hospital in Troy, the Troy Bank and Trust Company petitioned the court for direction in carrying out the intent of the will of Governor Henderson as times had changed so greatly that even the definition of a ''crippled child'' was not the same. In 1935, when the will was written, a crippled child generally had paralysis left by poliomyelitis or tuberculosis of bone or other bone infections. In 1976, when the petition was filed, polio was nearly a thing of the past due to the success of the vaccines of Salk and Sabin. Further, tuberculosis now is rare, especially of bone. What is a crippled child today? A crippled child is one who is afflicted by a birth defect or any disease or condition that interferes with the attainment of normalcy — blindness, deafness, CP, burns, heart disease, and on and on.

So the court made some changes in the will, being most careful to retain the spirit and intent of the deceased. There's no need in Troy for a crippled children's hospital (there's not one in the State of Alabama anymore and such hospitals are indeed rare in the U.S. today). There's no need in Troy for a children's hospital (for children crippled or not). Many towns and cities much larger than Troy haven't got such (Montgomery doesn't, for instance). So an outpatient facility was the logical answer to provide health care to all children of Pike County and contiguous counties *regardless of ability to pay*.

The court thought it acceptable to offer services to ''all'' and therefore not discriminate against those willing and/or able to pay, *but* this facility should offer its services *free* to any who could not afford to pay for their outpatient medical care. After the court's clarifications and directions in regard to the original will, the Charles Henderson Memorial Association was established to develop plans for the facility that would be a suitable, indeed, an altogether fitting and proper memorial to this special man who loved children and was so concerned about their educational and medical needs.

Charles Henderson Child Health Center began operations in July of 1979 in temporary quarters and in the new facility in December of 1980.

What's available now and what's projected for the future? The President and Physician-in-Chief of the Center (Randolph Batson, M.D.) is a former professor of pediatrics, past dean and former vice chancellor at Vanderbilt and he has brought a wealth of experience and expertise in child health care to Troy.

Presently, there are two pediatricians who are in the work area five days a week and who cover their practice twenty-four hours a day, three hundred and sixty-five days a year (the author and Patricia Block, M.D.)

Three specialists see patients by appointment. The orthopedist from Montgomery (Dr. James Armstrong) is there once a month. The otorhinolaryngologist, also from Montgomery (Dr. John Starling), is there once a week and the ophthalmologist from Dothan (Dr. Don Barham) is there at least twice a month. The patients they see are doctor-referred, and again, the patients that are children are seen regardless of ability to pay.

There is a good relationship with the county board of education and there's a nurse who works part-time at the Child Health Center and for the county school system. Troy State University's School of Nursing rotates some of its students through the clinics. There are Crippled Children's Services clinics in ENT and eye that meet regularly, thereby sparing CCS patients in our area a lengthy trip to Montgomery or Dothan. Tel-Med is operational now (a service to doctors, but primarily to patients who may call to request that a tape that interests them be played and the RSVP person complies cheerfully). The mental health system now operates a clinic in the facility and the Center is proud of the affiliation with them. It's a truly unique arrangement.

Educational programs are continually being developed to help citizens who come to the facility, who are in the nearby hospital, who are in the schools and the community — in a drive toward ''wellness.'' The facility has been the location for several seminars and programs for the practicing physicians in the county and surrounding area and CME credit has been given for the participation. A joint project with the auxiliary of the nearby hospital has seen the beginning of a loaner program for child restraints whereby every baby may take a safe trip home in an approved restraint.

The Center has a sophisticated, computerized system for billing and for appointments and, very soon, for the accumulation of pertinent medical information thereby making clinical research an easier possibility in future days.

The sky is the limit as far as the future is concerned. The hope is to soon have a full- or part-time physical therapist to occupy the spacious area already assigned. Speech therapy is not that far away. Dental services for children in a fully equipped suite are forthcoming in a matter of months. Also, a dream, which should be a reality before too many days pass, is an academic affiliation with the pediatric department of one of Alabama's (or perhaps both) medical schools or indeed, a medical school of a neighboring state whereby residents in their last year of training (along with their wives and children when possible) would come to Troy and learn skills in office pediatrics. Perhaps some would learn to love rural America — a place where 20% of the people of this great country live but less than 3% of this country's doctors choose to practice their art.

''You can't take it with you.'' Charles Henderson knew that and so he left the lion's share of his wealth to children — important citizens of our country — our most valuable natural resource.

Does Charles Henderson stand tall? You bet he does! If no man stands taller than one who stoops to help a crippled child — what greater way can one "help" than to make health care available in a facility that is modern and has the best equipment possible?

I recently heard a preacher say that to him some of the saddest words in the Bible are these: "And all the days of Methuselah were nine hundred and sixty-nine years: and he died." Can you imagine living all that time? To me, that's quite an accomplishment, but to this preacher it was seen as tragedy — that much time on earth and all it says is that he died. It's possible Methuselah gave all his wealth to Mesopotamia Tech. He might have loved the Lord and sought to set up a big tabernacle. He may have nursed an invalid wife from the time she was four hundred and fifty till she died at eight hundred. But we don't know these things and it's rather sad.

"And all the days of Charles Henderson were close to seventy-seven years: and he died. *But* during life he accomplished many great things and further, he was a lover of children. He shall be remembered for all time as he left his great wealth to contribute mightily to the educational and health needs of generation upon generation of children."

Will there be any stars in the crown of Charles Henderson? It is not my intent, in this essay, to be an evangelist, but basically, I accept that most of you have knowledge of the Heavenly Home and how to get there. After getting there, an old hymn suggests that upon the crown of believers, stars are placed, one for each significant deed performed in this earthly life. Charles Henderson will have a "milky way" of stars weighting down his crown — one star for every child that has benefitted or will in the future benefit from his visionary generosity.

Photographs are helpful but they don't adequately capture the architectural beauty of the facility or the spaciousness and the convenience of the set-up that assures comfortable patient flow. If any of you are ever in our area of the state, the welcome mat is out. Seeing it is the only way to truly appreciate this totally unique medical wonder in the heart of rural Dixie.

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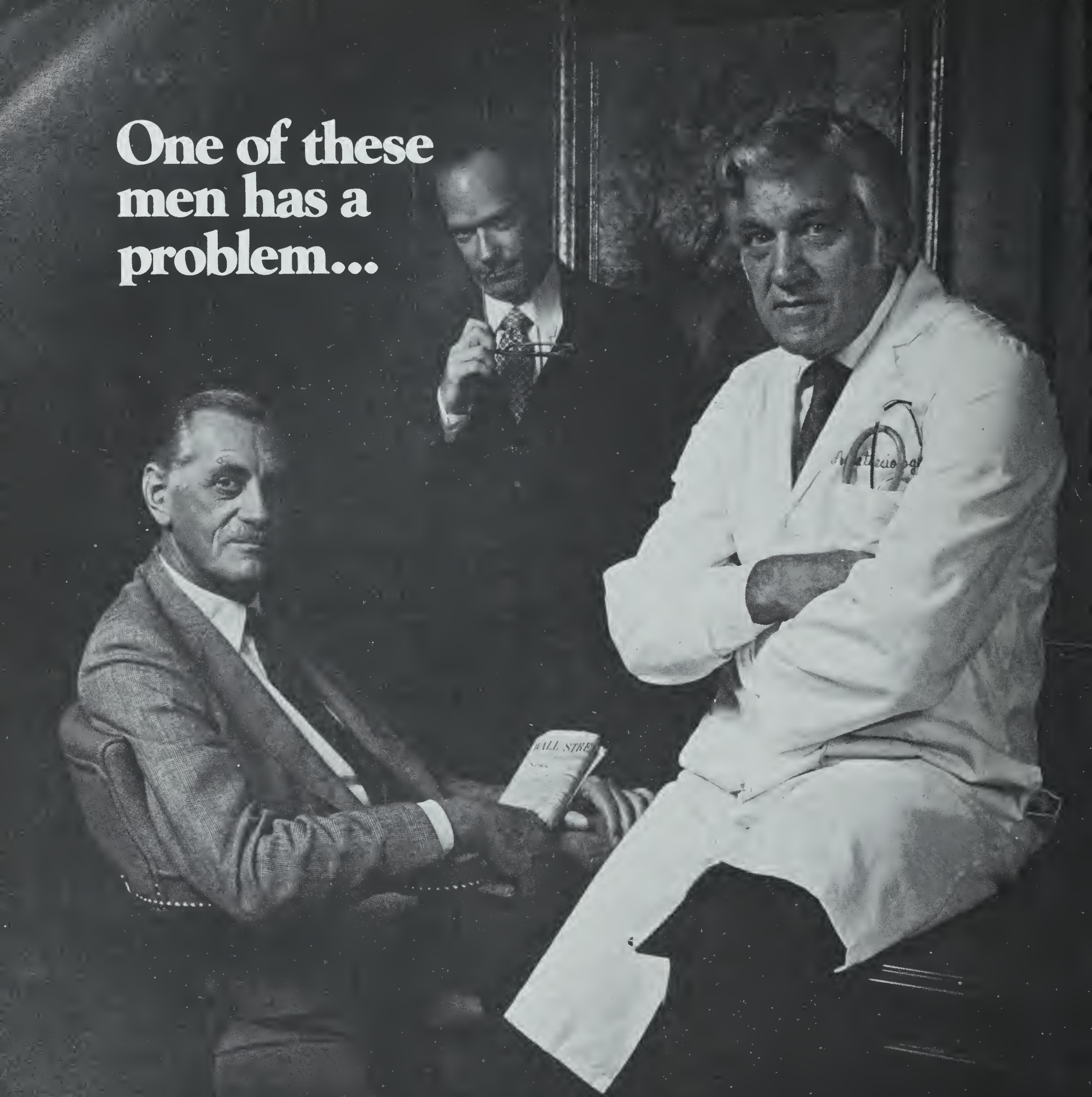

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Cellulitis Due to Aeromonas Hydrophilia

Curtis A. Smith, M.D.*
Frank A. Hall, Jr., M.D.†

Aeromonas hydrophilia is a gram negative rod that as the species name hydro (water) philia (to love) indicates, has its natural habitat in fresh or sea water where they commonly cause infectious diseases in aquatic, coldblooded animals.[1] It is not normally considered to be pathogenic for man but infrequent reports in the medical literature have identified it as a cause of gastroenteritis,[2, 3] meningitis,[4] and also septicemia in primary immunosuppressed patients.

Although Aeromonas has been isolated in two previously reported cases of cellulitis associated with freshwater contamination,[3, 6] we can find no previous reported cases of a subcutis infection from a saltwater source. We describe a case of cellulitis following a puncture wound from cleaning shrimp.

Case Report

A 62-year-old male suffered a puncture wound on the dorsum of his left hand while cleaning shrimp three days prior to admission. Mild redness and swelling appeared within twenty-four hours but the patient did not see a physician until three days later at which time he had severe swelling of the entire hand and forearm associated with nausea, vomiting and diarrhea. On the day of admission to the hospital, the patient became worse and developed fever, weakness and hypotension. Physical examination on admission revealed an acutely ill male with a temperature of 102.4° F. Blood pressure was 90/80. There was erythema and edema of the left hand and arm extending above the elbow; the swelling was most marked in the hand. A radial pulse was palpable. The patient was unable to move his fingers because of the pain and edema. Sensation was normal.

Laboratory data: Hematocrit Level 49%; WBC 13,900/cu. mm. A gram stain of the fluid aspirated from the dorsum of the hand revealed many gram negative rods. Blood cultures were negative.

In the hospital, the patient was started on continuous wet dressings and intravenous cephalothin, one gram every six hours. The patient was unimproved on the regime and the swelling and redness progressed to the shoulder. On the second day, the patient had gentamicin and chloramphenicol added to the antibiotic coverage. He developed large vesicles on the dorsum of the hand and after forty-eight hours the skin of the entire dorsum of the hand was necrotic. On the third hospital day, the patient had debridement of the skin of the dorsum of the hand except for a small island of viable epithelium overlying the tendon to the second digit (See Figure No. 1). Cultures of the debrided material revealed a pure growth of Aeromonas hydrophilia that was sensitive to ampicillin, carbenicillin, cephalothin, amikacin, gentamicin, tobramycin, chloramphenicol and tetracycline.

continued on page 48

* Associate Clinical Professor of Surgery, University of South Alabama College of Medicine.
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10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socio-economic problem that can undermine good nutrition.[2]

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candidates for

Rx ONLY **Berocca® Plus** TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION

continued from page 45

The patient was started on daily whirlpool treatments and the patient was maintained on gentamicin and chloramphenicol. Temperature returned to normal after seven days. On the thirteenth hospital day, the patient's hand was again debrided under general anesthesia. The veins of the dorsum of the hand were thrombosed and the necrosis included all superficial tissue and extended into the extensor tendons to the third and fourth fingers. All the necrotic tissue was removed and the patient was continued on antibiotics and daily whirlpool therapy following surgery. By the twenty first hospital day, healthy granulation tissue covered the dorsum of the hand and split thickness skin grafts were applied. Subsequent recovery was uneventful with satisfactory coverage of the skin grafts. Although the tendons were involved, their function returned and the swelling slowly subsided allowing the patient to resume full use of his hand.

Discussion: This case is similar to that reported by Hanson[6] of a patient who developed a severe cellulitis involving his forehead and face following a freshwater laceration. In both cases, there was a rather explosive onset of erythema and suppuration with fever, yet the freshwater wound caused no extensive tissue necrosis. The use of an aminoglycoside as one of three initial antibiotics may have lessened the clinical severity. Reports have generally indicated that Aeromonas hydrophilia is resistant to penicillin, ampicillin, cephalosporins and sensitive to tetracyclines, chloramphenicol and aminoglycosides. In this case, the organism was sensitive to penicillin and cephalosporin yet the infection progressed on cephalosporin alone. It was only after adequatea debridement and the addition of gentamicin and chloramphenicol that improvement occurred. Clinically this infection resembled either a necrotizing fascitis or Group A streptococcal infection that

Figure 1. Debridement of Severe Cellulitis of the Hand Caused by Aeromonas Hydrophilia.

failed to respond to initial treatment with cephalothin. After debridement and addition of gentamicin and chloramphenicol the infection was controlled. Initial antibiotic therapy in freshwater and saltwater wounds should include an aminoglycoside to allow for the possibility of an Aeromonas hydrophilia cellulitis.

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OB-GYN needed for 6-man multispecialty group in Crossville, a progressive city and vicinity of 30,000 population in East Tennessee, located on Cumberland Plateau, along Interstate 40. Drawing area of 75,000. Modern Clinic building adjacent to 250 bed accredited community hospital. No investment necessary. Guaranteed salary and fringe benefits. Abundant recreational facilities. CONTACT: Mrs. Louise Taylor, Business Manager, Cumberland Clinic Foundation, 301 Hayes Street, Crossville, TN 38555 (615) 484-5171.

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LOCUM TENENS — In Birmingham, Solo practitioner's office, internal medicine, for 2-3 weeks beginning Sept.-Oct. 1982. Reply in confidence to P.O. Box 6106, Birmingham, AL 35259. Dr. George Risman, giving experience, mal-practice insurance, etc.

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ENTERO-TEST® Adult, and Pediatric, a nylon line coiled inside of a gelatin capsule. The Pediatric string is 90cm and the Adult string is 140cm. Both capsules are designed to retrieve duodenal contents without intubation.

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Studies have confirmed the following applications for the Entero-Test:

PARASITES:

Those parasites that live primarily in the duodenum or bile ducts often are more readily seen in the duodenal contents than in the stool. These include Giardia lamblia (motile trophozoites), Strongyloides stercoralis (larvae and/or eggs in advanced stages of development), Clonorchis sinensis (eggs), Fasciola hepatica (eggs), Trichostrongylus orientalis (eggs), and Isospora (coccidia).

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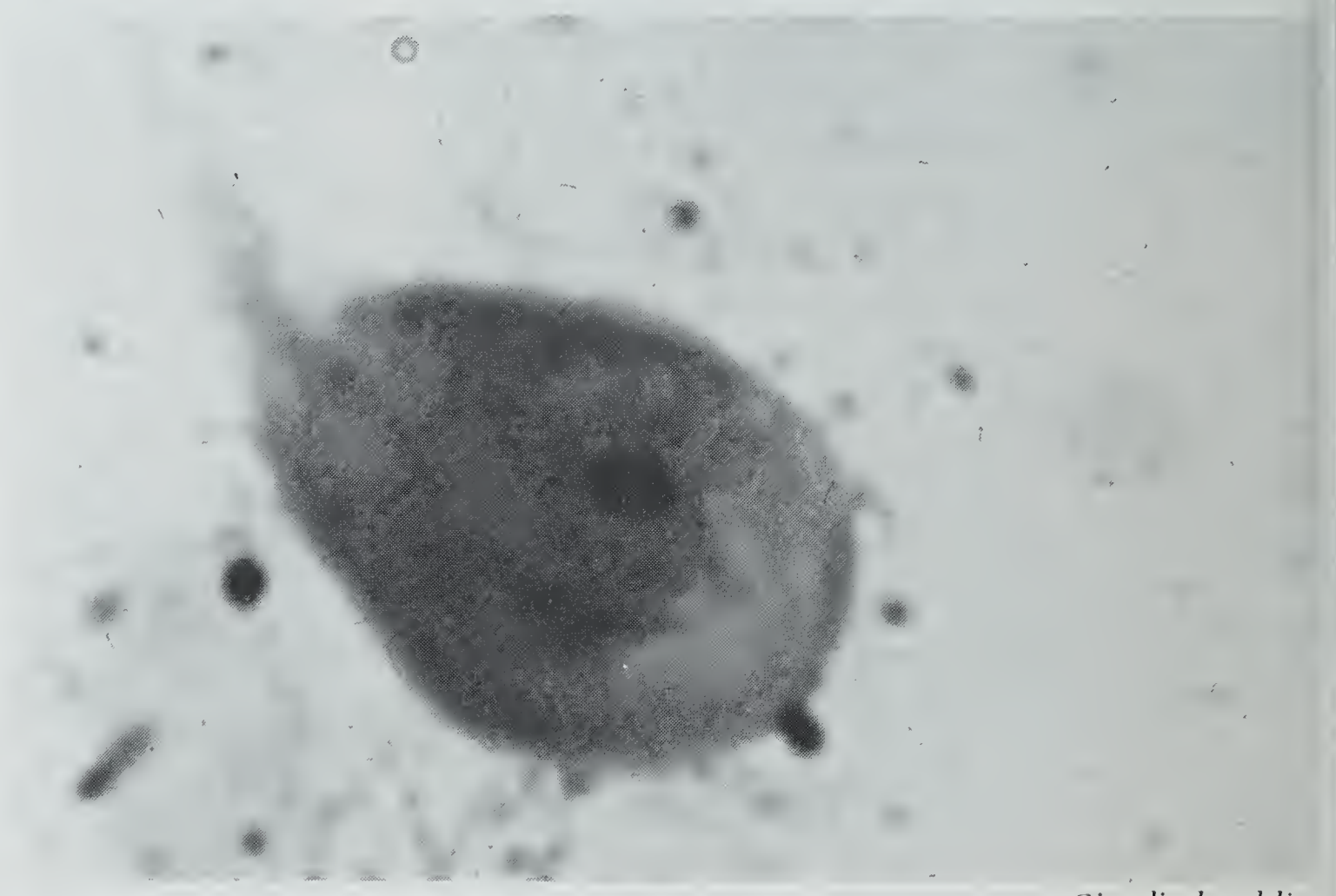

Giardia lamblia

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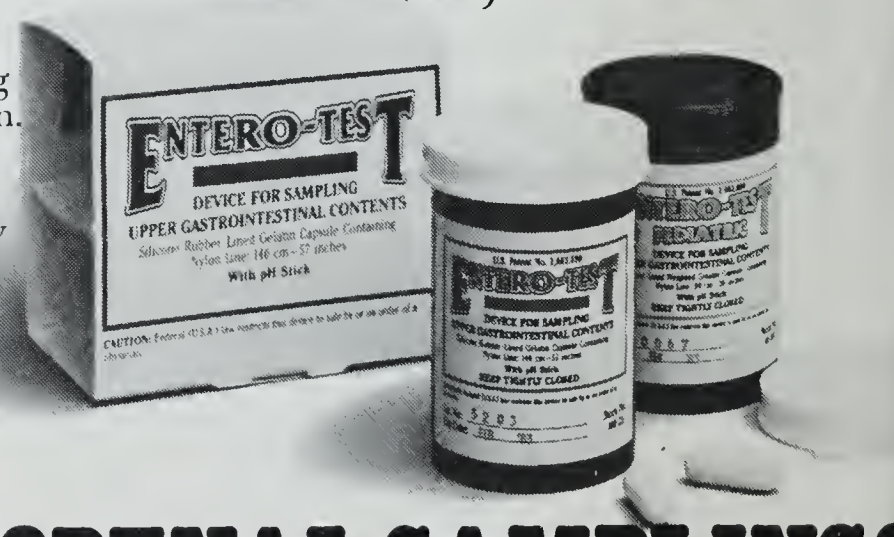

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Mrs. Robert Estock
President, A-MASA

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It is a non-profit, volunteer service organization made up of approximately 2,000 doctor's spouses in 33 active constituent auxiliaries throughout Alabama. The Auxiliary was founded in 1923 and its objectives are:

To assist the Association in its programs for the advancement of preventive medicine and securing adequate medical legislation for the people of Alabama;

To promote health education and support health related charitable endeavors; and

To foster fellowship among the medical community and act as a public relations arm of the medical society.

What are we doing?

We are helping through—

● *Legislation* — Our objectives are to assist the medical profession on the county, state and national level in the promotion of legislation which will safeguard the type of medical care most beneficial to the public. We act as an alert system to notify our members on current issues.

● *Community Health and Health Projects* — Taking an active role in educating and motivating people for better community health. Becoming aware of community needs, doing something constructive about them and then sharing our expertise with other Auxiliaries over the state and nation.

● *Health Education* — Health Education can improve the quality of life of all people. Continuing our efforts to stress health education for all individuals so that they can accept their responsibility in developing lifestyles that best prevent disease.

● *American Medical Association Education and Research Foundation (AMA-ERF)* — The Auxiliary provides aid to this non-profit organization dedicated to the support of medical education, research and financial assistance to medical students, interns and residents.

WE NEED YOUR SPOUSE

No matter how broad the program of the Auxiliary, how high its aim, nor how active its various committees; maximum efficiency in service to the medical profession and the public cannot be attained until every eligible physician's spouse in Alabama is an Auxiliary member.

If you live in an area where there is an organized auxiliary we urge your spouse to seek membership. These counties are: Blount, Calhoun, Chambers, Cherokee, Clay-Randolph, Coffee, Colbert, Covington, Dale, DeKalb, Elmore, Escambia, Etowah, Franklin, Geneva, Houston, Jackson, Jefferson-Bessemer, Jefferson-Birmingham, Lauderdale, Lee, Madison, Marshall, Mobile, Montgomery-Autauga, Morgan-Lawrence, Pickens, Pike, Russell, Talladega, Tallapoosa, Tuscaloosa-Hale, and Walker. If your county is not listed when your spouse is eligible to be a member-at-large. Just as MASA welcomes the Resident Physician/Medical Student member so do our state and national organization welcome their spouses.

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We really can do more together! ⊡

Patty

Yes, I am interested in joining the Auxiliary to the Medical Association of the State of Alabama. Please have the local membership chairman contact me.

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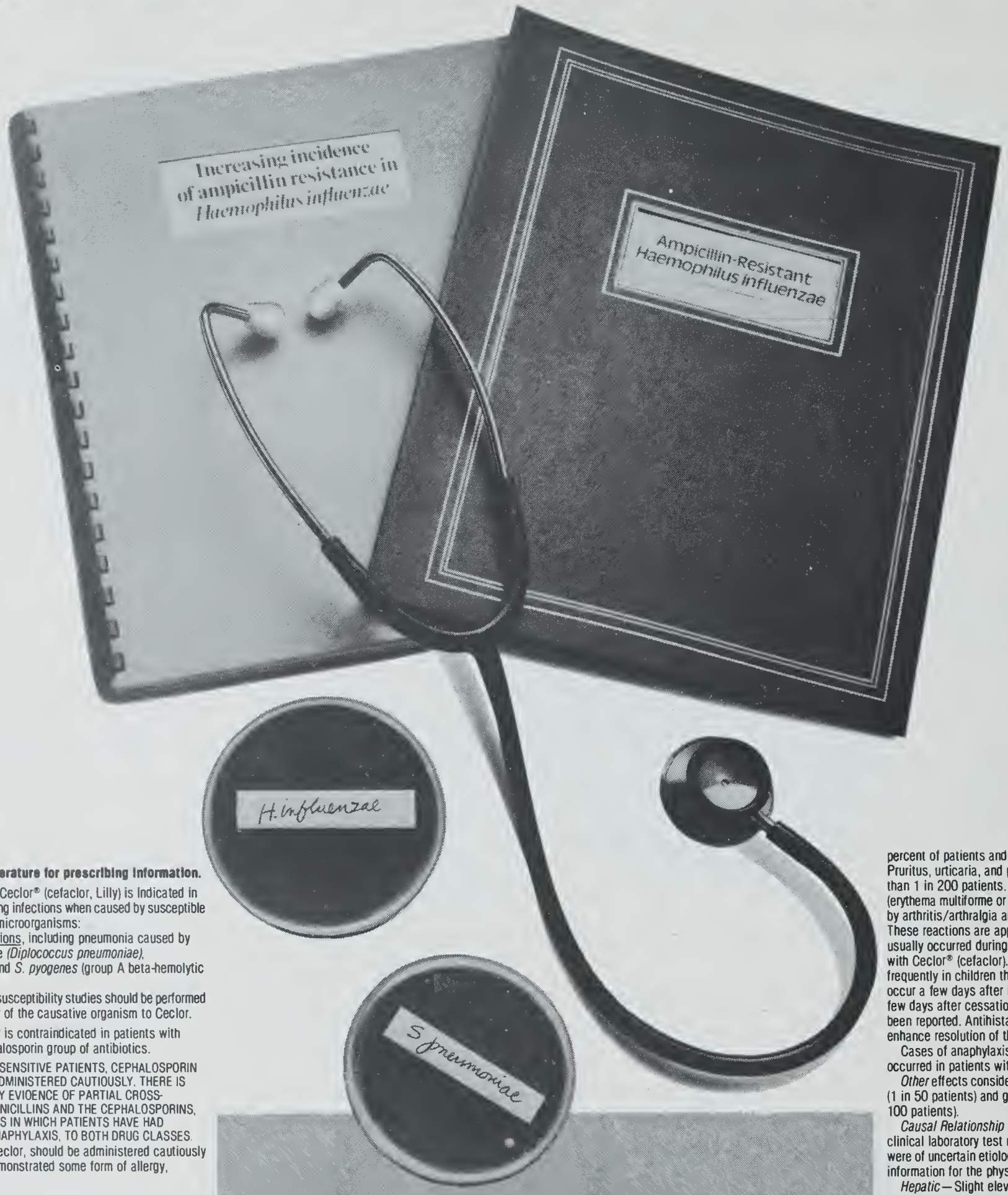
COMMENTS:

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-5]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coomb testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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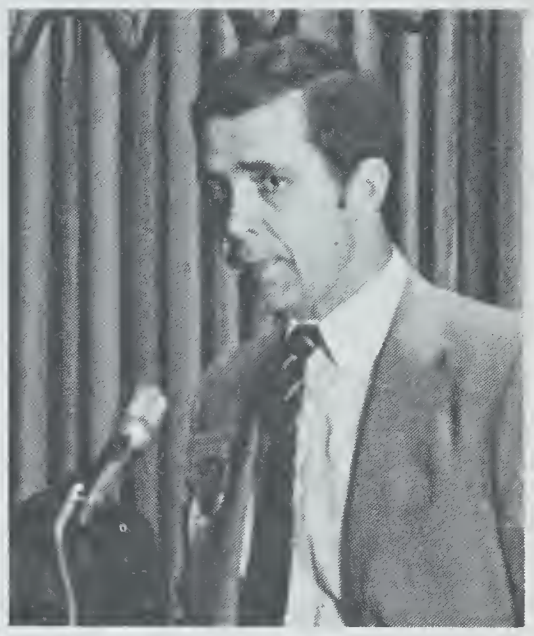
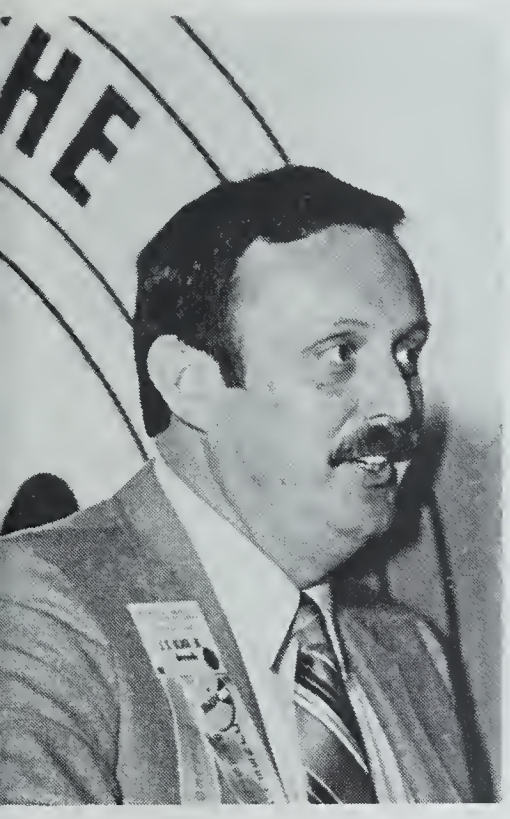
Some Glimpses of Annual Session, Huntsville, April 21-24

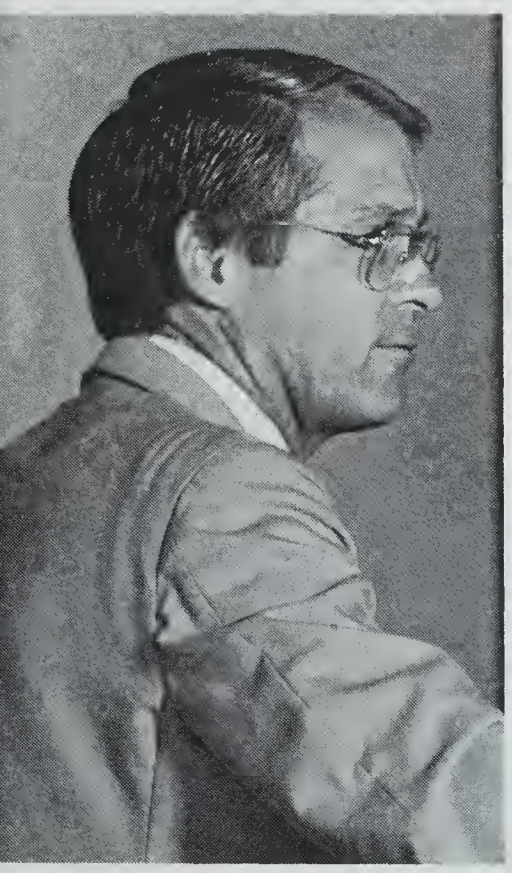


Ronald E. Henderson, M.D. was installed as 1982-83 president.



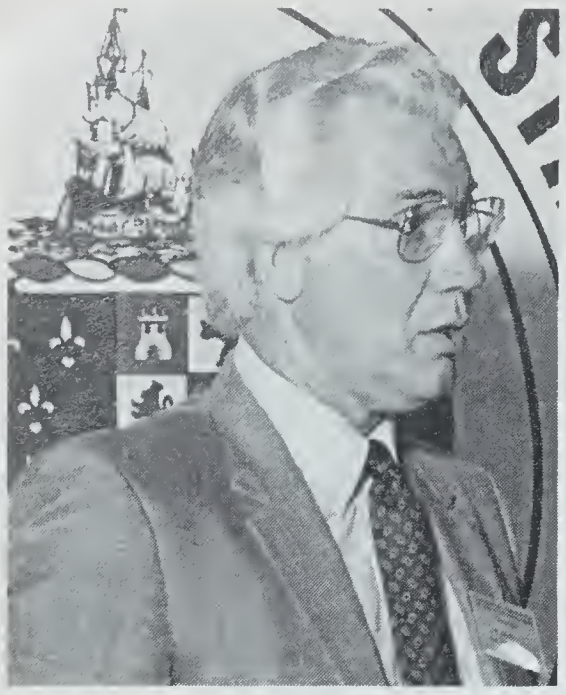
J. Kendall Black, Jr., M.D., concluding his 1981-82 presidency, told those at orientation session how Alabama Medicine is organized.

William T. Wright, M.D., past President, told another of his legendary jokes to illustrate MASA's attractions.



A Derrill Crowe, M.D., Mutual Assurance President, saw a malpractice crisis ahead far worse than that of the middle 1970s.

William A. Leitner, M.D., member of the Board of Censors and ALAPAC chairman, spoke of the necessary political involvement of medicine.



E. Gene Thrasher, Vice President, Blue Cross/Blue Shield of Alabama, described the increasingly critical role of third party payors.

Carl A. Grote, M.D., Chairman, Board of Censors, spoke on medical ethics.

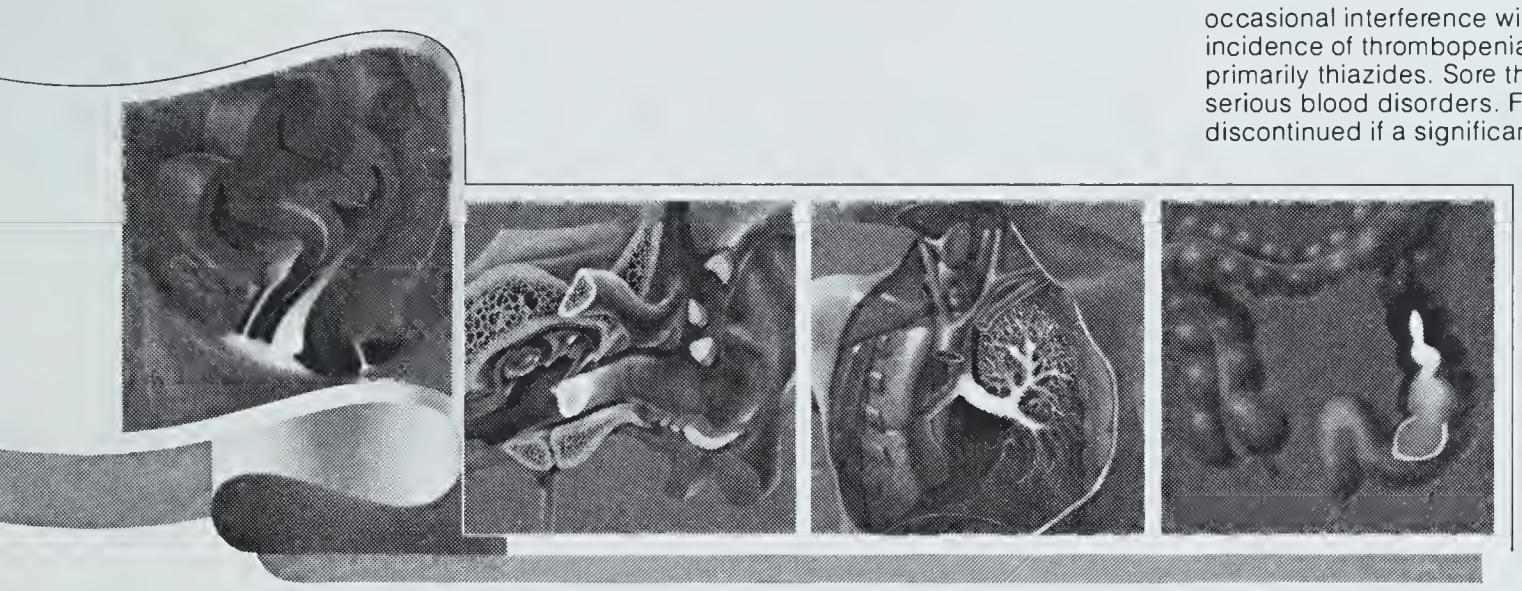
Kenneth C. Yohn, M.D., Chairman, Credentials Committee of the Board of Medical Examiners, told how some physicians come to grief.

Mrs. Rufus E. Lee, Jr., 1981-82 Auxiliary President, told the College of Counselors and House of Delegates of A-MASA's work during the year.

Bactrim™
(trimethoprim and sulfamethoxazole)
succeeds

Bactrim is useful for the following infections when due to susceptible strains of indicated organisms (see indications section in summary of product information):

Expanding its usefulness in antimicrobial therapy



in recurrent UTI...
a continuing record of high clinical effectiveness against common uropathogens

in acute otitis media in children...
effective against both major otic pathogens...with *b.i.d.* convenience

in acute exacerbations of chronic bronchitis in adults...
clears the sputum and lowers its volume...on *b.i.d.* dosage

in shigellosis...
faster relief of diarrhea than with ampicillin[2]

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:
Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry-flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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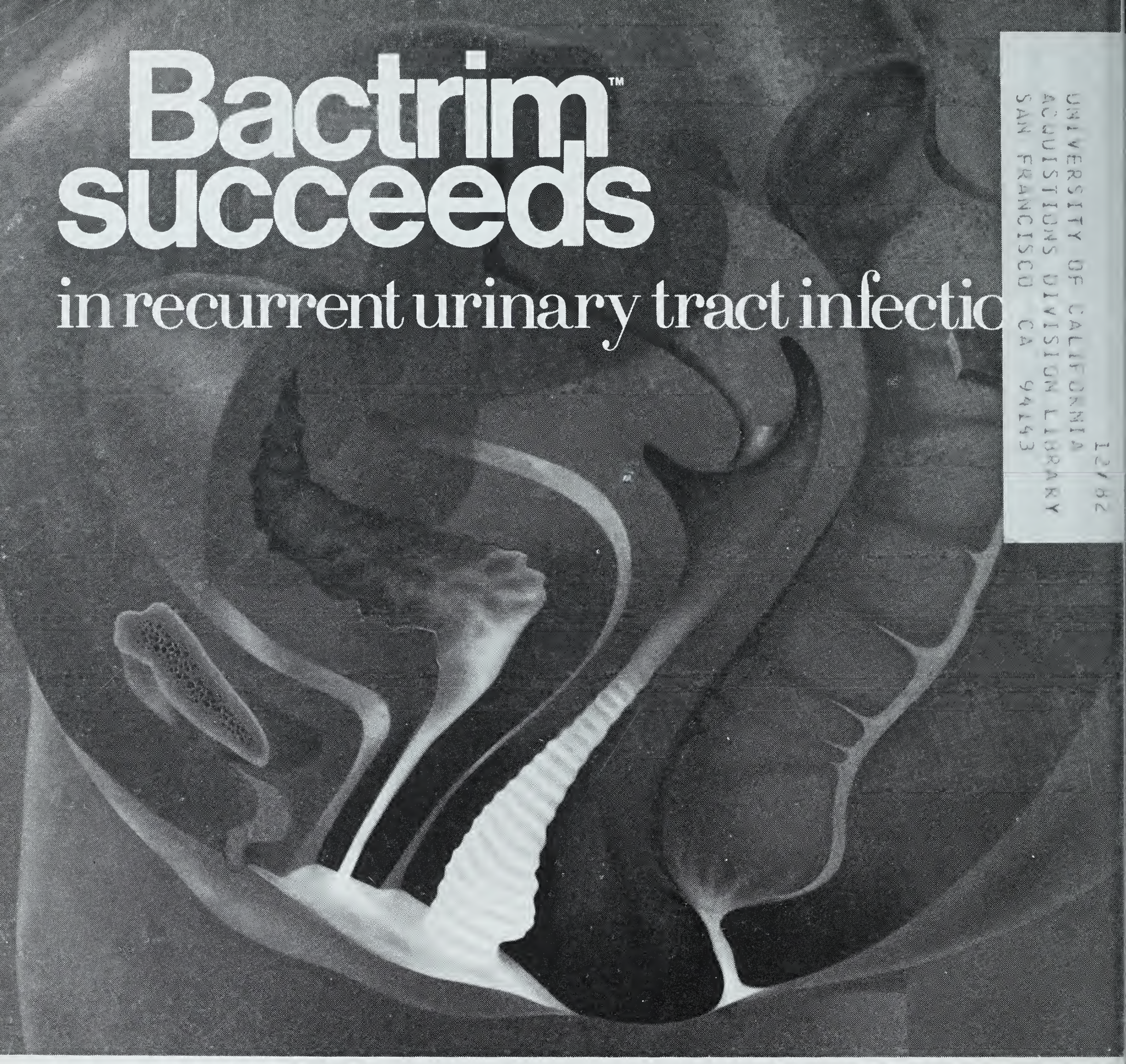
Bactrim™ succeeds

in recurrent urinary tract infectio



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Bactrim continues to demonstrate high clinical effectiveness in recurrent urinary tract infections. Bactrim reaches effective levels in urine, serum, and renal tissue[1]...the trimethoprim component diffuses into vaginal secretions in bactericidal concentrations[1]... and in the fecal flora, Bactrim effectively suppresses Enterobacteriaceae[1,2] with little resulting emergence of resistant organisms.

1. Rubin RH, Swartz MN: *N Engl J Med 303*:426-432, Aug 21, 1980..**2.** Data on file, Medical Department, Hoffmann-La Roche Inc.

Bactrim™ DS

160 mg trimethoprim and 800 mg sulfamethoxazole

DOUBLE STRENGTH TABLETS

maximizes results with B.I.D. convenience

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* due to susceptible strains of indicated organisms

Please see previous page for summary of product information.

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